South Africa

Country Operational Plan 2017 (COP17)

Strategic Direction Summary (SDS)

Final submission draft 16 March 2017

Public Version

Contents

1. Goal Statement

In support of the new 2017-2022 South Africa National Strategic Plan for HIV, Tuberculosis (TB), and Sexually Transmitted Infections (STIs)[1] (hereafter referred to as the NSP), the United States (U.S.) through the President's Emergency Plan for AIDS Relief (PEPFAR) Country Operational Plan 2017 (COP17) will implement a strategic portfolio of programs aimed at epidemic control. During COP17, PEPFAR will prioritize South Africa's (SA's) 27 highest HIV burden districts—accounting for 82% of SA's people living with HIV (PLHIV). PEPFAR support to the national HIV program is coordinated under the SA and U.S. governments' Partnership Framework Implementation Plan (PFIP). In partnership with the government of South Africa (GoSA) and development partners, PEPFAR will disrupt HIV transmission by prioritizing HIV prevention, orphans and vulnerable children (OVC), services for adolescent girls and young women (AGYW), scaling-up saturation of voluntary medical male circumcision (VMMC) for men (15-39 years), and reaching the Joint United Nations Program on HIV/AIDS (UNAIDS) 90-90-90 targets and beyond, especially in priority sex/age bands (women 25-34; men 25-34). In COP17, PEPFAR will work to achieve full attainment[2] in six of the 27 focus districts and saturation[3] of 90-90-90 in the remaining 21 districts by September 2018[4]. Through its TB/HIV interventions, PEPFAR will also support SA's national TB program.

PEPFAR supports the national rollout of Universal Test and Treat (UTT) and same-day initiation,[5] and new and efficient service delivery models aligned with the National Department of Health (NDoH) HIV Testing Services (HTS) and Adherence Policy and Guidelines. In order to achieve COP17's ambitious targets, PEPFAR will scale-up direct service delivery support to sites and accelerate health systems strengthening initiatives, including those focused on health financing, Human Resources for Health (HRH), information systems, laboratory services, quality of service delivery, and supply chain. The GoSA and PEPFAR will continue to innovatively use and share data to adaptively manage the HIV response, in collaboration with civil society, faith-based organizations (FBO) and implementing partners.

In COP17 PEPFAR SA inputs will focus on:

- Dramatically improving linkage to treatment and retention in care to above 90%;

[1] The NSP is scheduled for launch March 31, 2017. The NSP was developed through a robust consultative and data-driven approach.
[2] Attainment is defined as sub national units (districts) that have achieved >/= 81% Antiretroviral Treatment (ART) coverage among both males, and females in the following age bands: (1) <15 years, (2) 15-24 years, and (3) ≥25 years.
[3] Saturation is defined as sub-national units (districts) that have achieved the >/= 81% ART coverage for the PLHIV population overall.
[4] COP17 implementation will begin October 2017 and end in September 2018.
[5] UTT and same-day initiation policy launched in September 2016.

- Reaching more than 2 million people with new and efficient service delivery models (e.g., Adherence Clubs, Centralized Chronic Medicine Dispensing and Distribution);
- Layering and integrating combination prevention interventions to protect AGYW and marginalized populations in the highest-burden districts, including greater integration of interventions implemented under DREAMS;[6] and
- Accelerating testing, VMMC, and HIV treatment for men.

2. Epidemic, Response, and Program Context

2.1 Summary Statistics, Disease Burden, and Country Profile

SA is an upper-middle income country with significant influence in the sub-Saharan African region. SA's economy is one of the largest in sub-Saharan Africa, and its pluralistic makeup which encompasses a wide variety of cultures, languages, races, and religions, largely shaping its health profile. The population is estimated at 55.91 million, with approximately 51% (28.53 million) being female. Life expectancy at birth is estimated to be 62.4 years (65.1 years for females; 59.7 years for males) while the infant mortality rate is 33.7 per 1,000 live births. [7]

In 2016, the HIV disease burden is estimated to have increased, with an estimated 7,104,706 PLHIV.[8] The majority (55-60%) of HIV-infected adults are women. Black women aged 25-34 years have the highest prevalence at 31.6%, and highest incidence, at 4.54 percent.[9]

South Africa's HIV epidemic is largely driven by heterosexual transmission, with underlying behavioral, socio-cultural, economic, and structural factors influencing HIV transmission risk. These factors include population mobility and migration; economic and educational status; alcohol and drug use; early sexual debut; sexual and gender-based violence (GBV); low prevalence of male circumcision; lack of knowledge of HIV status; intergenerational sex; multiple and concurrent sexual partners; discrimination and stigmatization; inconsistent condom use, especially in longer-term relationships and during pregnancy/post-partum; and gender dynamics, including unequal power relations between men and women.

[6] DREAMS is the Determined, Resilient, Empowered, AIDS-free, Mentored and Safe Initiative for HIV Prevention among AGYW launched by GoSA and PEPFAR in 2015, with full implementation begun in April 2016.
[7] Statistics South Africa [StatsSA], Mid-year population estimates, 2016. Statistical Release P0302, Statistics, South Africa: Pretoria.
[8] Comprising: 351,025 children less than 15 years; 5,758,182 adults between 15-49 years; and, 995,589 adults 50 years and older. Source: Johnson LF, et al. (2016) Prospects for HIV control in South Africa: a model-based analysis. Global Health, Action. 9: 30314.
[9] Shisana, O, Rehle, T, Simbayi LC, Zuma, K, Jooste, S, Zungu N, Labadarios, D, Onoya, D et al. (2014) South African National HIV Prevalence, Incidence and Behaviour Survey, 2012. Cape Town, HSRC Press.

The GoSA-led current progress towards epidemic control includes a targeted HTS program, which has resulted in 3.8 million people on antiretroviral treatment (ART), including 171,536 children (<15 years) and 3,636,076 adults (1,206,080 males and 2,429,996 females, ≥15 years).[10] South Africa accounts for the largest national treatment program in the world, although with the recently adopted universal ART eligibility, overall treatment coverage is only 53.6% (48.9% for children; 47.5% for adult males; and 57.7% for adult females).[11] With respect to VMMC, it is estimated that 47.5% of males aged ≥15 years will be circumcised in 2016.[12] In 2016, progress was made with the adoption of UTT, same-day initiation, differentiated service delivery, including the establishment of centralized chronic medicines dispensing and distribution (CCMDD) models as vehicles towards universal access to ART and multi-month Antiretroviral (ARV) supply, and pre-exposure prophylaxis (PrEP) targeted at key population groups. Additionally, in June 2016, the GoSA launched She Conquers, a national campaign and strategy for AGYW focusing on five crucial areas: (1) reducing HIV incidence; (2) decreasing teenage pregnancy; (3) decreasing GBV; (4) keeping girls in school; and (5) increasing economic empowerment opportunities for girls and young women.

Major programmatic and system gaps or barriers to achieving epidemic control remain. The number of new HIV infections remains high, with an estimated 266,618 new HIV infections in 2016, with these new infections disproportionately higher among AGYW.[13] The nexus with the TB epidemic continues to drive high morbidity and mortality, with the legacy of apartheid and significant income inequality posing additional challenges to the TB and HIV response.

Gross National Income (GNI) per capita is estimated at USD $6,800[14]. Total health expenditure is estimated to be about 8.93% of the gross domestic product (GDP) with health spending expected to reach R178 billion (approximately USD$ 13.7 billion) in 2017/18[15]. There is clear commitment by the GoSA to continuously increase budgetary support towards the HIV response. In the 2017 budget, an additional R885 million (approximately USD $68 million) was added to support the implementation of UTT.[16]

HIV prevalence and incidence vary significantly across geographic areas (54% of PLHIV are concentrated in the Gauteng and KwaZulu-Natal provinces)[17]. Tables 2.1.1 and 2.1.2 below summarize the key HIV epidemiological data and provide a national view of the 90-90-90 cascade.

[10] Johnson LF, et al. (2016) Prospects for HIV control in South Africa: a model-based analysis. Global Health Action. 9: 30314. The estimation of 3.8 million on ART includes estimations of private health providers ART clients.
[11] In the work cited (Op. cit.) 10
[12] Op. cit. 7
[13] Op. cit. 10
[14] World Bank: World Development Indicators. Online: http://data.worldbank.org/indicator/
[15] Op. cit. 12
[16] National Treasury, 2017 Budget Speech. Online: http://www.treasury.gov.za

Table 2.1.1 Host Country Government Results															
	Total		**<15 years**				**15-24 years**				**≥25 years**				***Source, Year***
			Female		**Male**		**Female**		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	55,908,900	100 %	8,315,788	14.9%	8,491,453	15.2%	5,076,221	9.1%	5,112,942	9.1%	15,137,128	27.1 %	13,775,333	24.6%	*Statistics South Africa, Mid-year population estimates, 2016*
HIV Prevalence (%)		12.8 %		2.2%		2.2%		11.1%		3.3%		23.3 %		16.8 %	*Johnson LF, et al. (2016). Prospects for HIV control in South Africa: a model-based analysis. Global Health Action. 9: 30314.*
AIDS Deaths (per year)	146,307		N/A	AIDS deaths in male & female children <15= 14,082	N/A		N/A	AIDS deaths in female adults ≥15= 60,557	N/A	AIDS deaths in male adul	N/A		N/A		*Johnson LF, et al. (2016). Prospects for HIV control in South Africa: a*

										ts ≥15= 71,668					*model-based analysis. Global Health Action. 9: 30314.*
# PLHIV	7,104,796		N/A	#PLHIV Children (<15) = 351,025	N/A	#PLHIV Adults (15-49) = 5,758,182	N/A	#PLHIV Adults (≥50) = 995,589	N/A		N/A		N/A		*Johnson LF, et al. (2016). Prospects for HIV control in South Africa: a model-based analysis. Global Health Action. 9: 30314.*
Incidence Rate (Yr.)		1.07 %		0.49%		N/A		2.54%		0.55 %		1.62 %		1.29 %	*Shisana et al. (2014), South African National HIV Prevalence, Incidence and Behaviour Survey, 2012*

New Infections (Yr.)	266,618														*Johnson LF, et al. (2016). Prospects for HIV control in South Africa: a model-based analysis. Global Health Action. 9: 30314.*
Annual Births	1,198,861	100 %													*Statistics South Africa, Mid-year population estimates, 2016*
% of Pregnant Women with at least one ANC visit	N/A	97%	N/A	N/A			N/A	N/A			N/A	N/A			*United Nations International Children's Emergency Fund (UNICEF), 2008*
Pregnant Women needing ARVs	N/A	N/A													

Orphans (maternal, paternal, double)	1,560,000 Maternal; 2,530,000 Paternal; 820,000 Double		N/A		N/A		N/A		N/A		N/A		N/A		*UNAIDS South Africa Spectrum, 2016*
Notified TB Cases (Yr.)	294,603		N/A		N/A		N/A		N/A		N/A		N/A		*World Health Organization (WHO) (2016). Global Tuberculosis Report, 2015*
% of TB cases that are HIV infected	157,505	57%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	*WHO (2016). Global Tuberculosis Report, 2015*
% of Males Circumcised		46.4 %			N/A	N/A			N/A	N/A			N/A	N/A	*Shisana, et al. (2014), South African National HIV Prevalence, Incidence and Behaviour*

															Survey, 2012
Estimated Population Size of Men who have sex with men (MSM)*	654,979 (621,205 - 688,753)	N/A													*South African National AIDS Council (SANAC), 2015*
MSM HIV Prevalence	N/A	28% (range of 22% - 48%)													*University of California, San Francisco (UCSF), 2015*
Estimated Population Size of Female Sex workers (FSW)	195,299 (185,357 - 205,240)	N/A													*SANAC, 2015*
FSW HIV Prevalence	85,560	56%					N/A	N/A			N/A	N/A			*SANAC, 2015*
Estimated Populati	75,701	100%													*SANAC, 2015*

on Size of People who inject drugs (PWID)															
PWID HIV Prevalence	10,598*	14.0 %													*Scheibe, et al, 2014 *Number calculated using prevalence rate of Scheibe et al applied to SANAC estimated population size of PWID*
Estimated Size of Priority Populations: Military	73,104	100 %													*South African National Defense Force (SANDF), 2015*
Estimated Size of Priority Populations: Black African Females 15-34 years	7,530,319	100 %													*Statistics South Africa, Mid-year population estimates, 2016*

Estimated Size of Priority Populations: Black African Males 25-49 years	8,038,652	100 %													*Statistics South Africa, Mid-year population estimates, 2016*

References-

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SANAC Programmatic Mapping and Size Estimation Study of Key Populations in South Africa, 2015 Final Report, October 2015

Scheibe, A, Brown, B, dos Santos, M, Rapid assessment of HIV prevalence and HIV-related risks among people who inject drugs in five South African cities, draft study report v2, 2014

Shisana, O, Rehle, T, Simbayi, LC, Zuma, K, Jooste, S, Zungu, N, Labadarios, D, Onoya, D et al. (2014). South African National HIV Prevalence, Incidence and Behaviour Survey, 2012. Cape Town, HSRC Press

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UNICEF Antenatal Care Coverage Data

World Bank: World Development Indicators. Online: http://data.worldbank.org/indicator/

World Health Organisation [WHO] (2016). Global Tuberculosis Report, 2015

Table 2.1.2 90-90-90 Cascade: HIV Diagnosis, Treatment and Viral Suppression (12 months)									
				HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART		
	Total Population Size Estimate (#)	HIV Prevalence (%)	Total PLHIV (#)	On ART[18] (#)	Retained on ART 12 Months (%)	Viral Suppression 12 Months (%)	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	55,908,900[19]	12.2%[20]	7,104,796	3,437,467	74%[21]	79%	10,498,232[22]	924,735[7]	852,401
Population less than 15 years	16,807,241	2.2%	351,025	169,878	N/A	N/A	N/A	N/A	29,461
Pregnant Women	1,171,479[23]	29.7%	347,929	N/A	N/A	N/A	1,028,311	202,458[24]	197,932[7]
MSM	1.2 million – 1.4 million[25]	28% (range of 22%-48%)	336,000	33%	33%	N/A	26,175	N/A	N/A
FSW	153,000[26]	56.0% (range of 40%-89%)	85,560	23.6 % (range of 19%-27.8 %)[27]	23.6% range (19%-27.8%)	N/A	17,881	N/A	N/A
PWID	67,000[28]	14.0%		N/A	N/A	N/A	N/A	N/A	N/A
Inmates	159,331[29]	No data	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Priority Population (Military)	73,104	No data	N/A	N/A	N/A	N/A	N/A	N/A	N/A

[18] DHIS. Nov 2016 (public sector data)

[19] Stats SA, 2016.

[20] Shisana, O et al. (2014). South African National HIV Prevalence, Incidence and Behaviour Survey, 2012. Cape Town, HSRC Press

[21] Under-reported in DATIM

[22] Figure is for clients aged 15-49 and excludes ANC

[23] UNICEF Antenatal Care Coverage Data

[24] As reported in DATIM

[25] USCF. MSM in South Africa: Data Triangulation Project. 2014

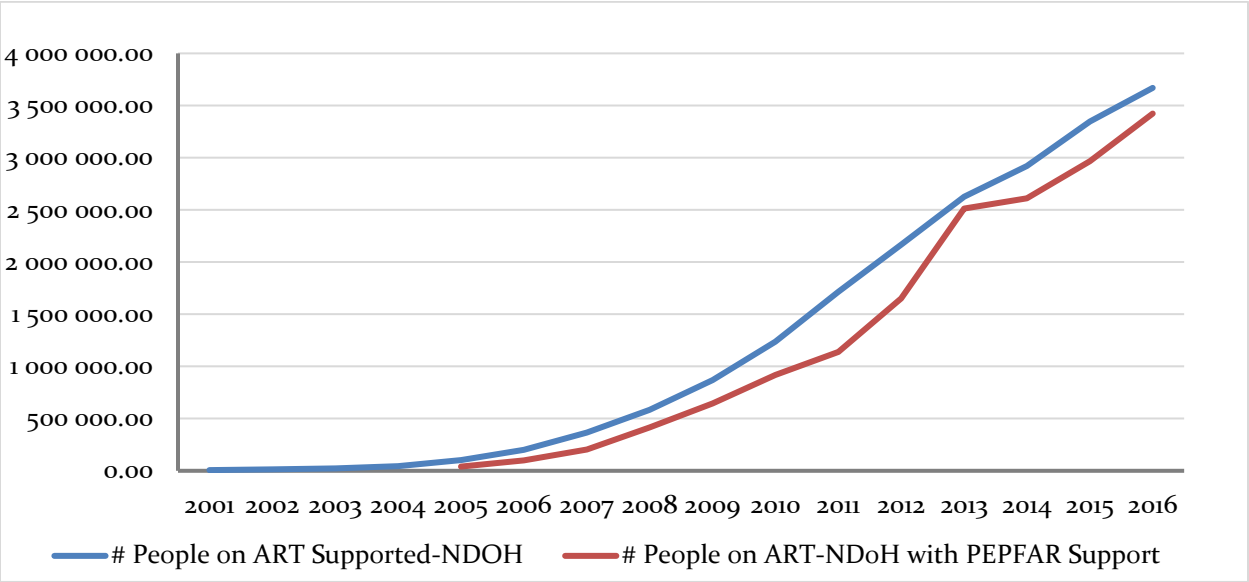
[26] The South African National Sex Workers HIV Plan 2016-2019. SANAC, 2016

[27] IBBS & Konstant 2013 and Stakeholder consensus (Feb 2017) for data for 12 districts (City of Johannesburg Metropolitan Municipality, eThekwini Metropolitan Municipality, City of Cape Town Metropolitan Municipality, City of Tshwane Metropolitan Municipality, Nelson Mandela Bay Municipality, Ehlanzeni District Municipality, Mangaung Metropolitan Municipality, Gert Sibande District Municipality, uMgungundlovu District Municipality, Capricorn District Municipality, Ngaka Modiri Molema District Municipality, Pixley ka Seme District Municipality)

[28] Petersen, Z et al. Availability of HIV prevention and treament services for people who inject drugs: findings from 21 countries. Harm Reduction Journal 10(1), 2013.

[29] Department of Correctional Services (DCS). Annual Report, 2014. Note: The DCS can house 159,331 inmates at any given time, but due to overcrowding and rapid turnover of inmates, the annual inmate population is estimated at 322,000.

Figure 2.1.1. National and PEPFAR SA Trend for Individuals Currently on Treatment



2.2 Investment Profile

The HIV response in SA is funded through public revenue, external development partners (donors) and the private sector.

In 2016/17, the SA HIV response was funded primarily through the GoSA at R17.32 billion (USD $1.31 billion[30]). PEPFAR was the second largest source of funds, and contributed R5.88 billion (USD $399.75 million XRT[31] 14.71[32]). The Global Fund to Fight AIDS, TB and Malaria (The Global Fund) was the next-largest funding source, and will contribute USD $311.8 million over three years in its current funding cycle, 2016-19. The 2013 National AIDS Spending Assessment reported other external sources (bilaterals, multilaterals, and foundations) accounting for about 3% of HIV response funding. Private companies and insurance contributed around 8 percent.

Within the GoSA response, the NDoH is the largest spender on HIV services, primarily via the conditional grant (R20.5 billion in 2018/19), followed by Department of Social Development (DSD) (R1.8 billion for 2018/19). An additional R1.9 billion is being allocated in 2017/18 and 2018/19 to support implementation of the HIV and TB Investment Cases and the new NSP including the continued expansion of providing ART to PLHIV. PEPFAR's anticipated FY2018 HIV funding in SA is R6.28 billion[33].

Due to the high HIV burden in SA, and the already large number of patients on treatment, HIV costs are expected to increase over the next decade, primarily driven by ART costs. Modeling undertaken as part of the SA HIV and TB Investment Case found that maximizing prevention

[30] Based on department budgets; 13.2 Exchange Rate
[31] XRT = exchange rate
[32] PEPFAR FY 2016 Expenditure Analysis; 14.71 Exchange Rate
[33] COP 2017; 13 Exchange Rate (USD $483million); USD $51.5 million for VMMC is additive this amount.

efforts (specifically condom provision, VMMC and social and behavior change communication) were more cost-effective than treatment, and that an approach that combines treatment and prevention is necessary to achieve the 90-90-90 targets. This strategy requires a steadily increasing investment in HIV programs to reach 90-90-90. Given SA's constrained economy, the GoSA has leveled funding for many services, and future rising HIV and TB treatment costs are projected to consume an increasing share of the health budget.

Table 2.2.1 Investment Profile by Program Area					
Program Area	**Total Expenditure**	**% PEPFAR**	**% GF**	**% Host Country**	**% Other**
Clinical care, treatment and support	$900,111,344	14.41%	4.10%	81.49%	N/A
Community-based care, treatment, and support	$122,378,625	18.96%	2.98%	78.06%	N/A
PMTCT	$44,320,990	43.27%	0.00%	56.73%	N/A
HTC	$128,789,795	51.00%	0.00%	49.00%	N/A
VMMC	$77,678,185	66.37%	0.00%	33.63%	N/A
General & Priority population prevention (including condoms)	$175,626,414	11.24%	19.07%	69.70%	N/A
Key population prevention	$27,690,185	24.57%	37.54%	37.89%	N/A
OVC*	$71,381,054	60.45%	0.00%	39.55%	N/A
Laboratory	$147,847,277	4.88%	0.34%	94.78%	N/A
SI, Surveys and Surveillance**	$33,139,947	69.72%	23.52%	6.76%	N/A
HSS**	$12,898,073	81.16%	18.84%	0.00%	N/A
Other: Program Management***	$64,161,143	0.00%	17.64%	82.36%	N/A
Other: Training/Capacity Building***	$12,504,135	0.00%	0.00%	100.00%	N/A
Total	**$1,818,527,167**	**21.98%**	**5.86%**	**72.16%**	**N/A**

There is no information on the Government of South Africa's Communications, M&E, Other Prevention, Policy and Systems Development spending and budget allocations because data were unavailable and/or not disaggregated in the Basic Accounting System (BAS); this does not mean that the GoSA is not spending anything on these activities.
*The GoSA does not track OVC investments in their basic accounting system. OVC investments in this table include DSD HIV/AIDS investments and DBE life skills education grant. This does not mean the GoSA is not investing in OVC programming in their other departments.
**SI and HSS in the PEPFAR expenditure are included across all program areas. The SI and HSS expenditures are not directly allocated to program areas.
***PEPFAR's program management costs and training costs are built into the program areas, whereas associated costs for the GoSA are separated out. Training and capacity building for the GoSA are from the HIV CG for Regional Training Centers.
The GoSA figures are based on their departmental budget allocations for FY2016/17 (XRT: 13.2). PEPFAR data are based on FY2016 expenditures. The Global Fund figures come from the final approved PR budgets.
The investment profile table is a broad profile of expenditures and budgets for HIV spending in SA, and is not meant to be comprehensive of all HIV expenditures in SA.

Table 2.2.2 Annual Procurement Profile for Key Commodities[34]					
Commodity Category	**Total Expenditure (USD$)**	**% PEPFAR**	**% GF**	**% Host Country**	**% Other**
ARVs	$339,524,206	0%	3%	97%	N/A
Rapid test kits	$9,669,786	3%	0%	97%	N/A
Other drugs	$35,036,771	0%	0%	100%	N/A
Lab reagents	$7,008,116	11%	8%	81%	N/A
Condoms/Viral Load commodities	$39,595,579	1%	0%	99%	N/A
VMMC kits	$12,360,457	50%	0%	50%	N/A
MAT	N/A	N/A	N/A	N/A	N/A
Other commodities	$627,587,817	3%	2%	95%	$0
Total	**$1,070,782,732**	**68%**	**13%**	**95%**	**0%**

[34] Table 2.2.2 notes: Rapid test kits XRT 13; budget estimate FY2017/18, VMMC kits, Condoms XRT 13.2; FY 2016/17, Other drugs & commodities are from FY2014/15.

Table 2.2.3 Annual USG Non-PEPFAR Funded Investments and Integration					
Funding Source	**Total US Government(USG) Non-PEPFAR Resources**	**Non-PEPFAR Resources Co-Funding PEPFAR IMs**	**# Co-Funded IMs**	**PEPFAR COP Co-Funding Contribution**	**Objectives**
USAID MCH	N/A	N/A	N/A	N/A	N/A
USAID TB	$15,000,000	N/A	N/A	N/A	To provide Technical Assistance to the GoSA on TB. USAID received an additional (one-time) USD $3 million in FY16 to respond to the White House National Action Plan for Combating Multidrug Resistant TB
USAID Malaria	N/A	N/A	N/A	N/A	N/A
Family Planning	N/A	N/A	N/A	N/A	N/A
NIH	N/A	N/A	N/A	N/A	N/A
CDC (Global Health Security)	N/A	N/A	N/A	N/A	N/A
Peace Corps	$2,300,000	N/A	N/A	N/A	N/A
DoD Ebola	N/A	N/A	N/A	N/A	N/A
MCC	N/A	N/A	N/A	N/A	N/A
Total	**$17,300,000**	**N/A**	**N/A**	**N/A**	**N/A**

Table 2.2.4 Annual PEPFAR Non-COP Resources, Central Initiatives, PPP, Headquarter Operation Plan (HOP)						
Funding Source	**Total PEPFAR Non-COP Resources**	**Total Non-PEPFAR Resources**	**Total Non-COP Co-funding PEPFAR IMs**	**# Co-Funded IMs**	**PEPFAR COP Co-Funding Contribution**	**Objectives**
DREAMS Innovation	$6,791,971	N/A	N/A	N/A	N/A	N/A
VMMC – Central Funds	$51,503,884	N/A	N/A	N/A	N/A	N/A
LCI	N/A	N/A	N/A	N/A	N/A	N/A
Other PEPFAR Central Initiatives	$1,753,327	N/A	N/A	N/A	N/A	Implementation Science; SI Country Model; PopART
Other Public Private Partnership (PPP)	$2,500,000	N/A	N/A	N/A	N/A	VMMC and UTT Demand Creation via Airtime Voucher Messaging; HCT in Private Sector Pharmacies; Improving Management and Leadership for the HIV response
Total	**$62,549,182**	**N/A**	**N/A**	**N/A**	**N/A**	

2.3 National Sustainability Profile Update

The GoSA, UNAIDS and the PEPFAR team worked together during COP16 planning to develop a draft 2016 Sustainability Index and Dashboard (SID). The SID was approved by the SA leadership, and has been shared and presented in various stakeholders' meetings through the PFIP and other fora including the Health (Development) Partners Forum and SA National AIDS Council (SANAC)'s Civil Society Forum.

The SA SID shows sustainable and approaching sustainability elements in each of its four domains.[35] In COP17, programs will continue that address issues identified in the SID, including service delivery; HRH; commodity security and supply chain; quality management; laboratory; epidemiological and health data; policies and governance; and civil society and private sector engagement.

[35] The four domains of the SID include: Governance, Leadership and Accountability; National Health Systems and Service Delivery; Strategic Investments, Efficiency and Sustainable Financing; and Strategic Information.

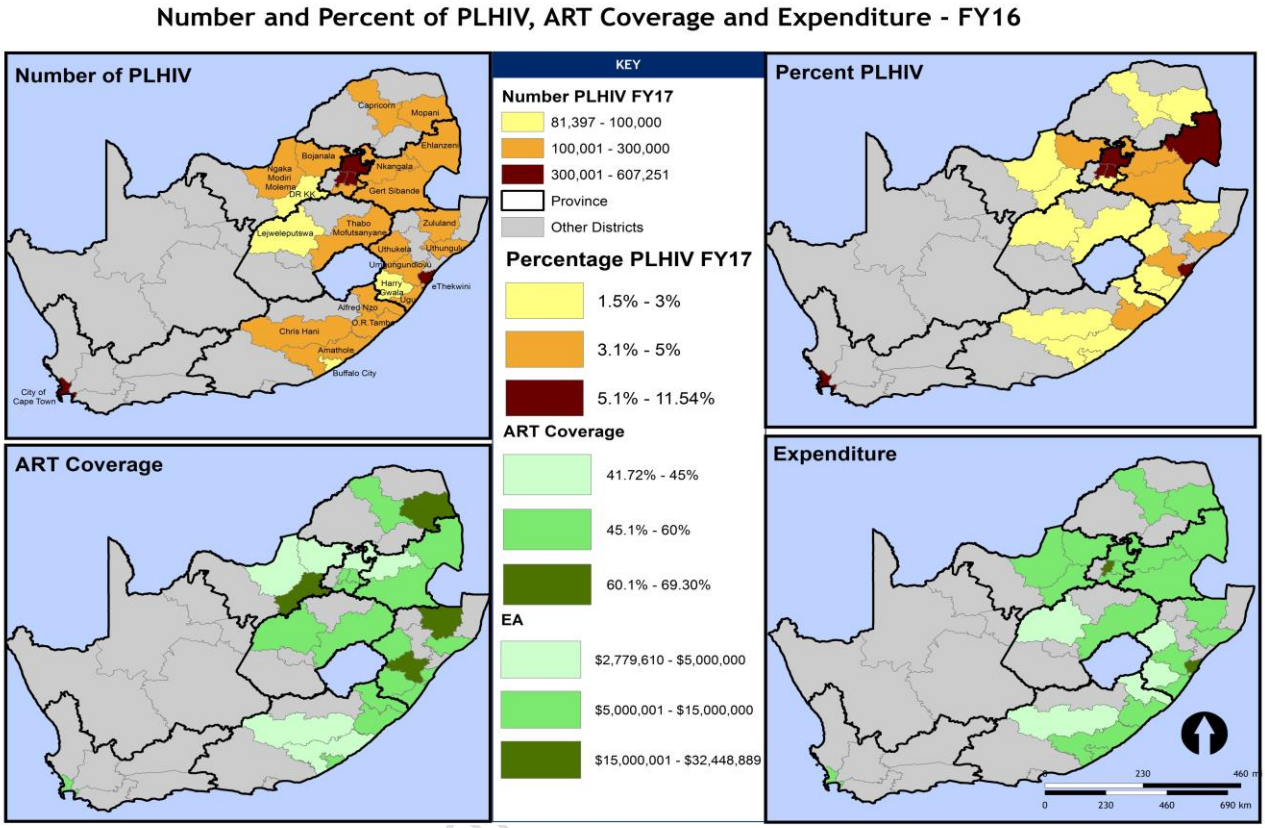
Through increased regular outreach and meetings with stakeholders PEPFAR SA is working with the GoSA departments and other funders to complement the ongoing, routine sharing of information regarding the various initiatives that support SA's health and HIV/AIDS programs.[36]

2.4 Alignment of PEPFAR Investments Geographically to Disease Burden

Figure 2.4.1 compares PEPFAR expenditure to burden of disease by district (as measured by the number of PLHIV). In 2016, the PEPFAR program spent an average expenditure of USD $42.54 per PLHIV. In general, relatively more funds were expended in the urban areas (e.g., Johannesburg and eThekwini) compared with non-urban areas, which may be reflective of the underlying population size associated with urban-based programs and DREAMS. The GoSA is responsible for the majority of HIV programs expenditures. Among the 27 focus districts contained in this submission, the expenditure per PLHIV ranged from US$17-US$83. The PEPFAR program has reviewed its available epidemiological and expenditure data in an effort to focus on programs and locations for increased impact and epidemic control in COP17. During COP16 implementation PEPFAR will support the NDoH to generate and make use of age/sex cohorts from Tier.net. This will provide additional program monitoring information and tracking efforts towards program improvement.

[36] PEPFAR SA leadership is routinely engaged in coordination and information sharing discussions through the regular bilateral PFIP structures, SA's Global Fund Country Coordinating Mechanism (CCM), the Health (Development) Partner Forum, the HIV and TB Think Tanks, information sharing with key foundations such as Clinton Health Access Initiative (CHAI), Bill and Melinda Gates Foundation (BMGF) and others which assist in the coordination and leveraging of PEFPAR investments in the various key intervention areas identified in the SID.

Figure 2.4.1 Percent PLHIV by Sub-National Unit (SNU), total PLHIV by SNU, and coverage of total PLHIV with ART and expenditure by SNU.



2.5 Stakeholder Engagement

The GoSA is a key stakeholder and leader in PEFPAR's program. Under the bilateral U.S and SA governments' PFIP, joint technical workstreams oversee the implementation of the PEPFAR SA program. These workstreams are guided by the PFIP Management Committee, co-chaired by the Deputy President's Advisor for Health and Social Sector and the interagency PEPFAR Coordinator, along with representation of senior officials from all the key GoSA departments. The bilateral partnership is led by the PFIP Steering Committee, co-chaired by the Minister of Health and the U.S. Ambassador to South Africa, along with the deputy ministers from key GoSA departments. The COP17 plan has been reviewed and discussed with the workstreams and Management Committee, and will be reviewed with the Steering Committee prior to the COP17 review, April 24-26, 2017.

The COP17 plan also has been reviewed and discussed with Civil Society through meetings with PLHIV organizations, U.S. Embassy Community Grants outreach meetings to the 27 focus districts, and the overall SANAC Civil Society Forum. Information has been shared electronically and is also posted on the U.S. Embassy's website. Representatives from these organizations have been invited to the COP17 reviews in Johannesburg, Gauteng Province.

PEPFAR has shared the COP17 plan and planning process with bilateral and multilateral stakeholders through both the Health Partners Forum and the United Nations (UN) Regional Coordinator's Office. Additionally, the interagency PEPFAR team has shared both with key foundations and other partners including BMGF, CHAI and others. Additionally, in COP16 and into COP17, PEPFAR will increase its engagement with the private sector, developing collaborative opportunities through large employers.

3. Geographic and Population Prioritization

In COP17 prevention services are strategically planned to support and align with the new NSP, She Conquers, DREAMS, and with the overall geographic focus. Updated district-specific analysis of the burden of HIV and projected treatment coverage progression over time by age group and sex have led PEPFAR to update and accelerate the treatment coverage targets of the current 27 focus districts. To reach epidemic control in these districts, six districts, representing 30% of the overall HIV burden, are expected to achieve "attained" treatment coverage by the end of COP17. The remaining 21 focus districts, representing 49% of the overall HIV burden, will achieve "saturation" treatment coverage (see Table 3.1 below). In COP17 PEPFAR will work with the GoSA, other funding partners, implementing partners, Civil Society, private sector and CBOs/FBOs to accelerate increased PLHIV findings and linkage to treatment. To support accelerated achievement PEPFAR will work with the GoSA and implementing partners to provide a mix of facility support interventions. These facility-focused interventions will include "roving mentoring teams", additional short-term clinic staff support, and secondments of PEPFAR-funded staff.

She Conquers is in 22 sub-districts, and is receiving support from DREAMS in four of these sub-districts. She Conquers is also receiving support for AGYW in 13 PEPFAR-supported scale-up districts and in 10 Global Fund-supported districts. Scaling up targeted HTS in the 27 focus districts will support reaching the first 90. In COP17 PEPFAR will support the GoSA in the implementation of the National Department of Basic Education's (DBE) HIV, TB and STIs policy. The policy covers prevention, care and support within the school context. PEPFAR will work with DBE and other departments and partners to operationalize the policy in DREAMS districts. Other prevention interventions will support the first and second 90s (e.g., mobilization and linkages) and primary prevention. Priority population prevention interventions for AGYW and under 30 year-olds in general will be implemented in 14 of the 27 focus districts, in sub-districts and their wards with the most

vulnerable young people (those who fall below the poverty line). Key population (KP) programs will be provided in 15 high-burden districts and three non-focus districts, based on high KP presence and HIV burden (e.g., metropolitan areas, truck stops, mining areas).

In COP17 PEPFAR SA will continue to work with the GoSA to support programs that address specific population groups as follows:

AGYW, their partners, and parents: SA has the highest number of estimated new HIV infections globally per week (2,363) among AGYW aged 15-24 years (UNAIDS, 2013). The CAPRISA 2016 phylogenetic study shows that sexual partnering between young women and older men significantly increases young women's HIV risk, and is a key feature of the sexual networks driving HIV transmission. Targeted combination prevention strategies need to include interventions to address age-disparate sexual partnering.[37] PEPFAR SA will continue to aggressively support the GoSA's goals to address HIV incidence among AGYW to achieve an AIDS-free generation, particularly with concentrated DREAMS evidence-based efforts. In June 2016, the GoSA launched She Conquers, a national campaign and strategy for AGYW focusing on: (1) reducing HIV incidence; (2) decreasing teenage pregnancy; (3) decreasing GBV; (4) keeping girls in school; and (5) increasing economic empowerment opportunities for AGYW. PEPFAR prevention interventions will complement She Conquers, including HIV testing for 322,083 AGYW.

Males: In COP17 PEPFAR will continue to work with NDoH and Provincial Departments of Health (PDoH) to focus more services and improved access to men in general. Linked with the VMMC program, as well as HTS, there will be emphasis on increasing the linkages of HIV-positive males to treatment and as well-focused prevention messaging for HIV-negative men. Modeling suggests that uncircumcised men, aged 15-34, are a priority target population for prevention. With the GoSA, PEPFAR will focus on achieving the greatest magnitude and immediate reduction in HIV incidence by increasing services to men, and prioritizing circumcision of men within the 15- to 34-year-old age group. Miners, predominantly men, are a high-risk group due to their mobility, and continue to have the highest TB incidence among a working population group globally. Given the high rates of co-infection with HIV, PEPFAR will support HIV prevention and TB programs among approximately 32,000 miners.[38]

KP: Modelled estimates indicate that 9.2% of new HIV infections nationally are attributable to MSM, and 19.8%[39] are attributable to sex work.[40] Studies show an HIV prevalence of 40% - 72% among FSW[41] and 28% - 52% among MSM.[42] There are an estimated 138,000 FSWs[43] and 1.2 million MSM.[44] Although prisons are equipped to house 159,331 inmates, SA's inmate population is estimated at 320,000. High-risk sexual behaviours, gender dynamics, and injecting practices may contribute to new infections in these facilities. A peer-based prevention intervention, "Strengthening Prevention

[37] Transmission networks and risk of HIV infection in KwaZulu-Natal, South Africa: a community-wide phylogenetic study, CAPRISA, 2016.
[38] Target was set last year and was not changed this year. Originally, was under CareWorks and is now under Foundation for Professional Development.
[39] There are more recent estimation models of HIV transmission attributable to sex work, but these models use a "frequency-dependent" assumption which lead to underestimation in transmission data.
[40] South African Centre for Epidemiological Modelling and Analysis (SACEMA) 2010 cited in National Strategic Plan for HIV, TB and STIs, 2012-2016. SANAC, 2012. The SACEMA study took place in 2010.
[41] UCSF. South African Health Monitoring Survey, Survey on female sex workers in South Africa, 2013-2014. 2014.
[42] UCSF. MSM in South Africa. Data Triangulation Project. Pretoria, 2015.
[43] Sex Worker Education and Advocacy Task force (SWEAT). Estimating the size of the sex worker population in South Africa, 2013. Cape Town, 2014.
[44] ANOVA Health Institute, Elton John AIDS Foundation. Rapid Assessment of HIV Prevention, Care and Treatment Programming for MSM in South Africa. November, 2013.

Services" (STEPS) is a six-week module that teaches peers about HIV, risky sexual behavior, and the harms of injecting drug use. In collaboration with NDoH and Department of Correctional Services (DCS), a situational analysis focusing on risk behaviors and seroconversion in prisons will be carried out in COP17 to strengthen interventions to reach prisoners. In COP17 PEPFAR will work with PDoHs to support services to injecting drug users leveraging resources with other partners. While the program remains a small component, the HIV prevalence of PWID is 14%. In COP17 PEPFAR will work with provinces and implementing partners to rollout the "STEP-UP[45]" program. The PEPFAR support is complemented with funds and resources from Global Fund and other donors and focuses on HIV prevention, testing and linkages to ART.

Migrant (farmworkers): According to the NSP 2012-2016, HIV risk is higher among individuals with personal migration experience or who have sexual partners who are migrants. According to the 2011 Census, 759,127 households with an aggregate population of 2,732,605 (5.28% of SA's population) lived in farm areas, with large migrant populations. As a result, migrant farmworkers will constitute a special focus within the larger migrant population.

OVC: OVC programs play a critical role in identifying vulnerable children and families and referring them to services. In COP15, an analysis of the OVC burden was conducted and districts with the highest OVC burden were determined. These areas were largely aligned with the 27 highest-burden districts. In COP17, PEPFAR SA will support OVC services in collaboration with the Department of Social Development in the 27 focus districts, as well as the DREAMS district of uMkhanyakude, KwaZulu-Natal.

Laboratory: The laboratory program prioritizes activities and resources aligned with the 27 highest-burden districts. The program focuses on strengthening the delivery of comprehensive quality diagnostic services with the National Health Laboratory Services (NHLS) to support the accuracy and reliability of HIV point-of-care testing (POCT), improving laboratory quality management systems, minimizing waste, increasing a skilled laboratory workforce, and strengthening all pre- and post-laboratory analytical phases at facility level. During COP17, PEPFAR SA programs will continue to address viral load (VL) cascade improvements, including clinic-laboratory linkages.

Table 3.1 Current Status of ART saturation

Prioritization Area	Total PLHIV/% of all PLHIV for COP17	# Current on ART (FY16)	# of SNU COP16 (FY17)	# of SNU COP17 (FY18)
Attained	2,004,148/30%	1,097,809	0	6
Scale-up Saturation	3,253,656/49%	1,575,615	4	21
Scale-up Aggressive	N/A	N/A	23	0
Central Support(KP and correctional facilities)	1,431,535/21%	893,214	25	25

[45] STEP-UP is a harm and HIV reduction set of interventions focused on PWID.

4. Program Activities for Epidemic Control in Scale-up Locations and Populations

4.1 Targets for Priority Locations and Populations

In line with focus for impact decisions made in the COP15 planning and implemented in FY16, PEPFAR programming will support NDoH and PDOH services in the 27 highest-burden districts, which account for an estimated 82% of SA's PLHIV burden (see Figure 4.1.1 below). PLHIV estimates at the district level are based on the 2015 Spectrum AIDS Impact Model (AIM) estimates that generated provincial-level data and then were extrapolated to the district level based on population size. These district estimates were also triangulated with other HIV burden estimates (e.g., 2012 HSRC Household Survey, Small Area Estimations) with appropriate adjustments made to select districts.[46]

In COP17 unmet HIV treatment need and targeted coverage in the highest-burden districts, as a proportion of estimated PLHIV, were used as a basis for determining other program area targets with the overall goal to achieve at least 81% of all PLHIV on ART (see Figure 4.1.2 below) at the district level. By the end of COP17 implementation (September 2018, the end of the USG FY2018) PEPFAR plans to support the GoSA's provision of ART to 81% of the estimated PLHIV in all 27 focus districts, with attainment achieved in six districts (City of Johannesburg, eThekwini, Ekurhuleni, uMgungundlovu, Zululand, and Mopani).

In COP17 PEPFAR will work with the GoSA, other funding partners, implementing partners, Civil Society, private sector and CBOs/FBOs to improve linkages to treatment and achieve attainment (81% ART coverage for estimated PLHIV in 0-15; 15-24 and 25≥ male and female age cohorts in six focus districts while achieving saturation (81% ART coverage) in the remaining 21 focus districts. Additionally in COP17 PEPFAR will work with the GoSA to accelerate achievement of attainment and saturation through intensified models of facility-focused support including roving mentoring teams, short-term human resources staff support for three to six months, and secondments of PEPFAR-funded staff for up to 12 months.

In COP17, associated program area (e.g., HTC, VMMC, and OVC) coverage and achievement targets have been aligned with both need and these HIV treatment coverage goals (see Figure 4.1.3 below).

[46] PEPFAR SA, in consultation with a variety of stakeholders, reviewed the current PLHIV estimates against estimates using various Thembisa- and program-data based extrapolations. Given that the majority of estimates for district burdens where aligned at a relative level with the Spectrum and the fact that updated estimates, informed by the HSRC Household Survey, will be available later this year, PEPFAR SA decided to maintain the Spectrum-based estimates for COP17. There were, however, two districts that were adjusted to align directly with the Thembisa-based estimate (Cape Town increased and Nkangala decreased). This was based on triangulation of the various estimates to reported program data (e.g., current on treatment). PEPFAR SA will update district-level PLHIV estimates based on the upcoming survey and modeling data expected to be released later this year.

Figure 4.1.1: Percentage and Total Number of PLHIV by District, South Africa FY16

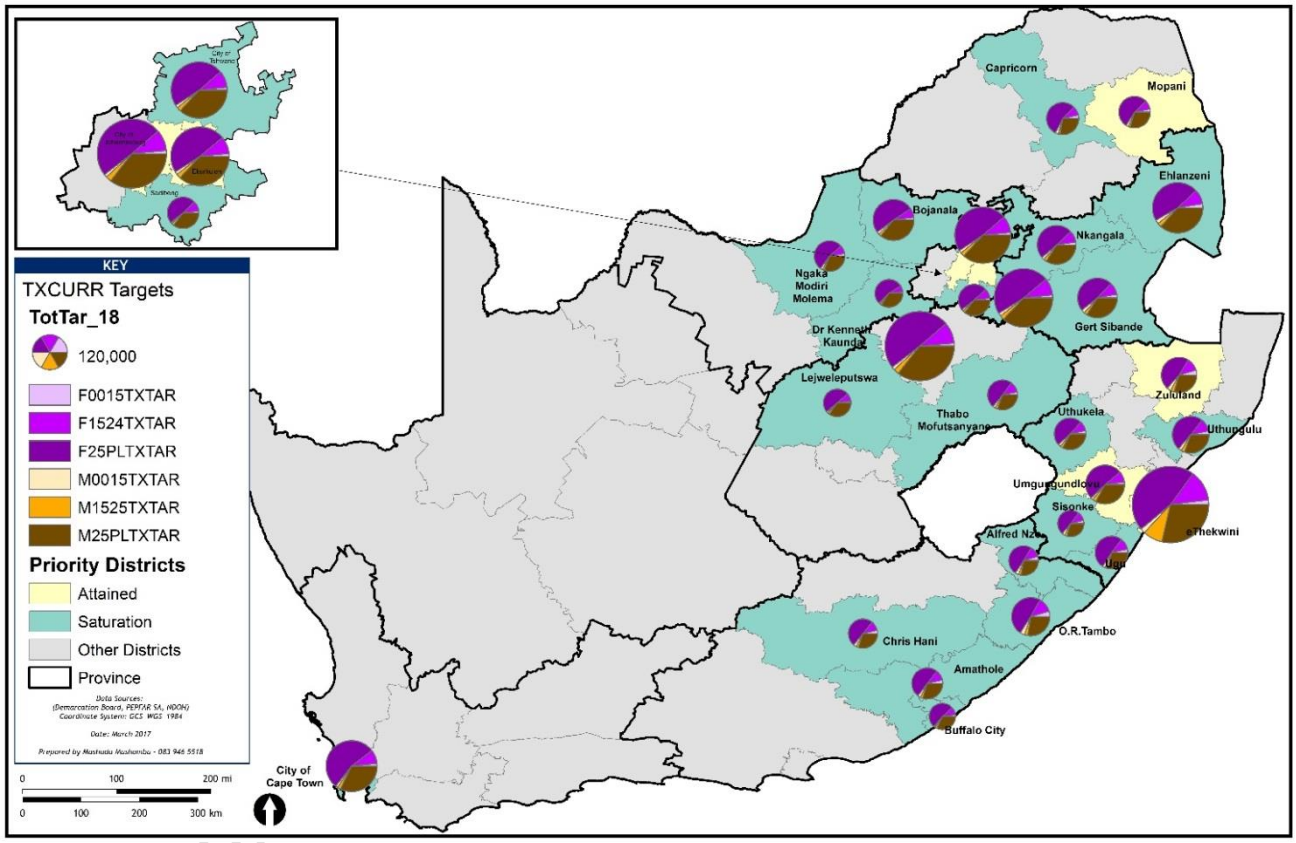


Figure 4.1.2: HIV Treatment Coverage and Unmet Need, South Africa FY16

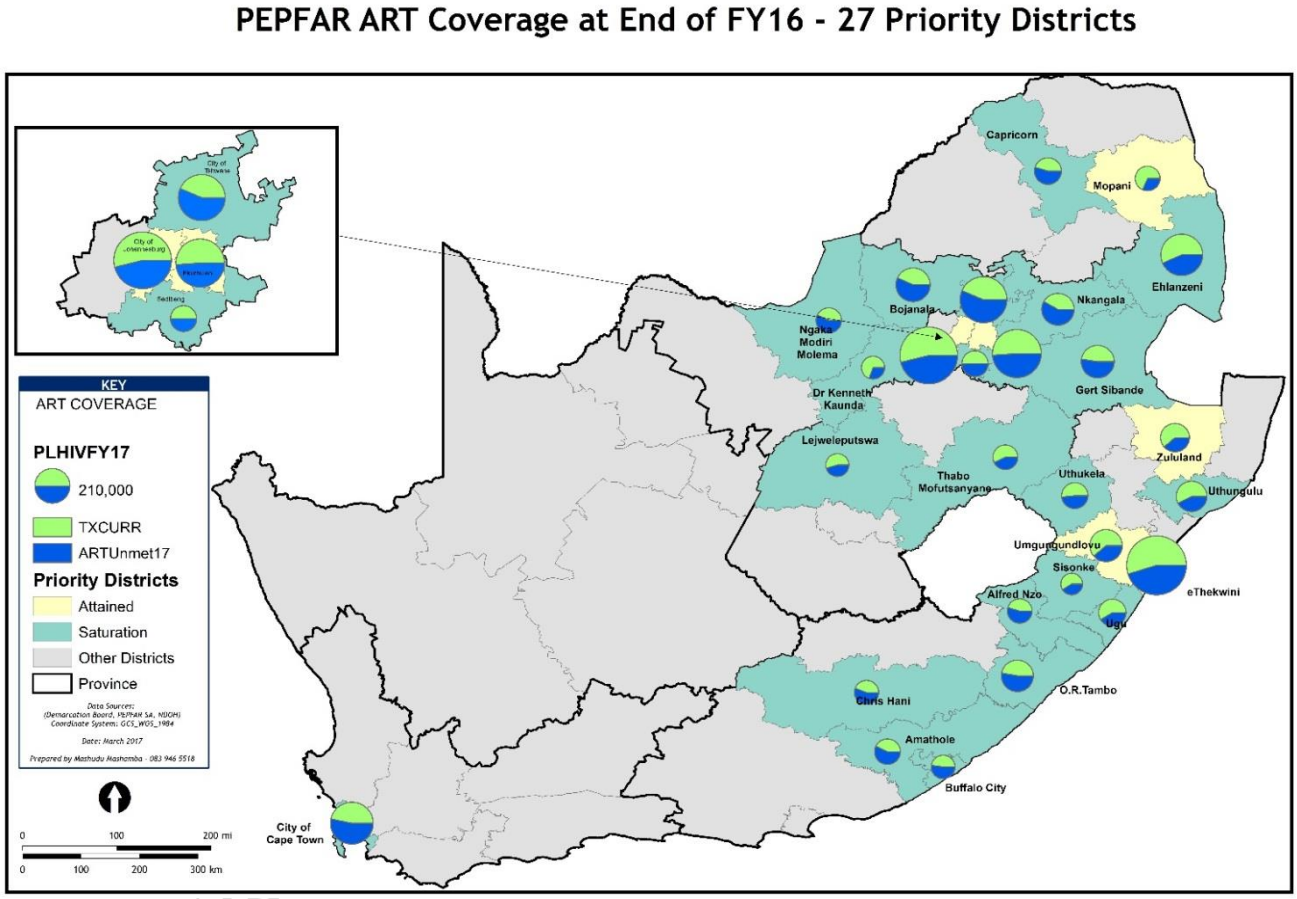
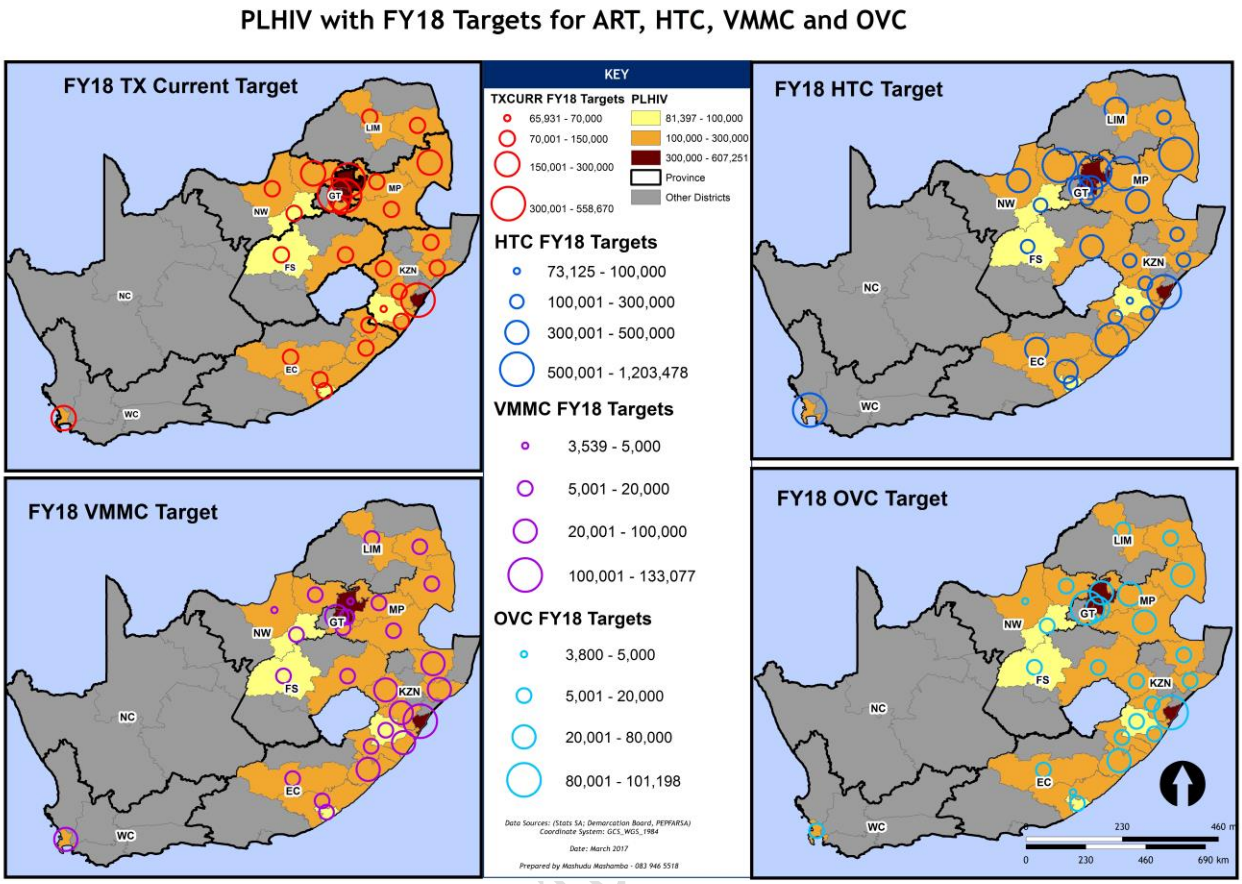


Figure 4.1.3: HIV Burden (PLHIV) with Treatment, HTC, VMMC, and OVC COP17 (FY18) PEPFAR Targets, South Africa



Laboratory:

COP17 laboratory program objectives were identified in discussions during portfolio reviews and subsequent meetings with the NDoH, NHLS, National Institute for Communicable Diseases (NICD), and the PEPFAR Laboratory Technical Working Group (TWG). Laboratory program activities will support both prevention and care and treatment interventions toward achievement of 90-90-90 goals. Laboratory program targets are aligned with the 1,969 supported facilities in the 27 highest-burden districts. The highest-volume HTS sites have been enrolled in the continuous quality improvement (CQI) program. PEPFAR will continue to expand the program to enroll all 1,969 facilities in COP17. Through capacity and strategy activities with NDoH and PDoHs, PEPFAR lab programs are leveraged to expand through these organizations to the other 25 districts and their facilities.

The program will continue to support NHLS in the implementation of Quality Assurance (QA) for HIV POCT to ensure the accuracy and reliability of testing for HIV-rapid test, early infant diagnosis and VL. For HIV-rapid test, PEPFAR implementing partners will provide QA to all PEPFAR-supported testing sites (facility, community, home-based, mobile testing) within the 27 priority districts and will align to recently released WHO Consolidated Guidelines on HTS and the national HTS revised guidelines. PEFPAR will support the GoSA laboratory program for implementation of QA for community-and home-based HIV-rapid tests (RT) and CD4 POCT for early infant diagnosis (EID). At the facility level, the laboratory program will facilitate implementation of QA for HIV rapid testing (RT) and strengthening of pre/post analytical phases (i.e., clinical-lab interface).

Targets for the implementation of the WHO-African Society for Laboratory Medicine (ASLM) step-wise accreditation process[47] to improve quality management systems in diagnostic laboratories have been set for 18 laboratories which provide HIV diagnostic services to facilities within the 27 priority districts.

In COP17 the laboratory program will assist in the achievement of the first and third 90 goals. Focus will be on addressing the low documented VL completion. Several key system barriers have been identified and the role of the laboratory program will be to provide key support to activities that will strengthen the current VL and EID testing cascade, as well as increase testing efficiencies of existing platforms within the VL laboratories, and intensify clinic-lab interface support to ensure proper handling and tracking of specimens, documentation, and capture of laboratory results in the relevant health information systems(HIS) to ensure improved uptake of the results for patients' management and reporting of VL completed.

Prevention: The prevention portfolio comprises several distinct programs in support of NSP goals including (a) VMMC; (b) HTS;[48] (c) priority population prevention; and (d) KP prevention.

VMMC targets are based on low medical male circumcision prevalence and high HIV incidence, with a goal to achieve 80% VMMC coverage of males 15-34 years by the end of FY18. Eleven of the 27 focus districts are expected to reach at least 80% coverage of males 15-34 by the end of FY17, with an additional 13 districts reaching 80% coverage by September 2018. To increase the immediacy of impact, VMMC programs will target the high priority age band with a goal that 80% of VMMCs reach 15-34 year old men. Active partner management and monitoring will be continued and expanded to ensure that PEPFAR-funded programs help realize the country's ambitious target for VMMC and achieving an AIDS-free generation.

As part of the VMMC program, referrals to HTS are an integral part of service delivery, and provide linkages to treatment for HIV-positive men. On average the HIV positivity rate is 4% among uncircumcised men presenting for VMMC services.

With additional COP17 central funds (approximately USD $51 million), PEPFAR will support the GoSA to achieve an additional 341,538 VMMCs, for a total of 581,656 VMMCs to support the VMMC goal of at least 80% of 15-34 year old men by September 2018. PEPFAR will work with implementing partners to ensure focus on the target age range, and apply findings from operations research to expand innovative methods to recruit older men. Demand creation focused on the target group is a COP17 VMMC program priority.

HTS: PEPFAR will work with the GoSA to aggressively scale-up community and facility testing in support of the first 90 with a strong emphasis on measures to improve linkage to treatment in alignment with UTT. Community testing will focus on the highest-yield modalities, specifically index case testing, as well as outreach testing activities in the community targeting the hard-to-reach high-risk populations, who do not utilize facility-based services, as described in detail in Section 4.5. In COP17 PEPFAR will work with the GoSA to support HIV testing for 10,084,374 people in facility and community settings, with a goal to identify 958,844 PLHIV who will be linked to treatment.

[47] Strengthening Laboratory Management Towards Accreditation (SLMTA) and Stepwise Laboratory Improvement Process Towards Accreditation (SLIPTA).

KP implementing partners will employ social network strategies, peer mobilization, and mapping to increase uptake and yield of hard-to-reach populations. High-risk HIV-negative individuals are urged to test regularly through risk reduction counselling and through peer networks.

Priority population prevention: In COP17 PEPFAR (including DREAMS activities) will work with the GoSA to focus on priority prevention sites in the highest-burden districts, with an emphasis on high-incidence areas, such as informal settlements, densely populated urban areas, mining areas, and trucking routes. DREAMS interventions will remain focused in the four scale-up saturation districts, plus uMkhanyakude. For AGYW and their partner populations, the denominator for COP17 is consistent between COP and DREAMS targets and is based on the proportion of local municipality populations living below the poverty line and within the target age groups (StatsSA, 2016). To determine GBV denominators, PEPFAR has used program data and Victims of Crime Survey, Medical Research Council (SAMRC) and South African Police (SAPS) report data. The recent SAPS 2015/2016 statistics released indicate that 110 rape reports are made every day in SA. PEPFAR will directly support 8,303 (15% of annual estimates) of all rape survivors who report, with comprehensive medical, legal and psychosocial services offered by trained and sensitive personnel. Support for rape survivors will also cover HTS, post-exposure prophylaxis (PEP) provision, pregnancy testing, and referrals. Condom dispensing and distribution support will take place in all priority population sites. Demand creation will be integrated into all interventions at all sites to improve uptake into clinical services, which in turn will lead to increased identification of PLHIV, providing the opportunity to link them to treatment.

KP prevention: KP activities will focus on high-burden populations, including FSWs, MSM, transgender women (including those who engage in sex work), people who inject drugs (PWID), and inmates. PEPFAR has used the best available data from PEPFAR and Global Fund programs and other sources (e.g., IBBS, Household Survey, UNAIDS) to determine KP denominators. PEPFAR will support the GoSA to reach 46% of FSW and 14% of the estimated MSM population in supported districts, and PEPFAR implementing partners in coordination with NDoH and PDoHs will test 55% of FSWs and 15% of MSM of unknown status in the districts in which they work. In collaboration with the GoSA, prevention interventions will reach 55% of inmates in all male correctional facilities in SA, and 7% of PWID in three PEPFAR-supported districts.

These programs will support the second 90 through systematic linkages to treatment for HIV-positive individuals through peer navigation, while regular adherence support groups and peer education will support the third 90. In COP17 PEPFAR will work with NDoH and PDoHs to implement innovative recruitment strategies to expand programs into new social networks. KP sensitization will include clinical competency training. A sensitization toolkit—inclusive of all KP—will be developed, piloted, and rolled out through the NDoH's Regional Training Centers and PEPFAR implementing partners. This toolkit will be used to train health providers and other government officials like Department of Correctional Services officials on gender orientation and identities, attempt to minimize stigmatization, and encourage respectful behavior. An additional focus will be on clinical competencies, such managing hormone-ART interactions for women.

The ongoing development of a KP cascade and unique identifiers will enable effective monitoring of the KP prevention and treatment cascades. PEPFAR's Site Improvement Monitoring System (SIMS) and other site visits will be utilized to monitor performance.

Table 4.1.1 South Africa ART Targets in Scale-up Sub-national Units for Epidemic Control						
District/Sub-national Unit[49]	**Total PLHIV**	**Expected current on ART (APR[50] FY 17)**	**Additional patients required for 81% ART coverage**	**Target current on ART (APR FY18) TX_CURR**	**Newly initiated (APR FY 18) TX_NEW**	**ART Coverage (APR 18) %**
ec Alfred Nzo District Municipality	103,600	51,047	32,869	83,916	19,326	81%
ec Amathole District Municipality	113,484	48,839	43,083	91,922	33,041	81%
ec Buffalo City Metropolitan Municipality	96,011	68,744	9,025	77,769	25,153	81%
ec Chris Hani District Municipality	101,129	44,754	37,160	81,914	29,716	81%
ec Oliver Tambo District Municipality	173,529	85,456	55,102	140,558	53,424	81%
fs Lejweleputswa District Municipality	90,448	50,106	23,157	73,263	10,997	81%
fs Thabo Mofutsanyane District Municipality	106,100	60,574	25,367	85,941	20,455	81%
gp City of Johannesburg Metropolitan Municipality	564,736	267,473	189,963	463,084	49,746	82%
gp City of Tshwane Metropolitan Municipality	372,026	162,369	138,972	301,341	93,171	81%
gp Ekurhuleni Metropolitan Municipality	404,750	275,230	52,618	327,848	61,893	81%
gp Sedibeng District Municipality	116,706	70,024	24,508	94,532	30,069	81%
kz eThekwini Metropolitan Municipality	607,251	340,318	151,555	558,671	98,895	92%
kz Harry Gwala District Municipality	81,397	47,835	18,097	65,932	8,351	81%
kz Ugu District Municipality	127,450	93,676	9,559	103,235	18,735	81%
kz uMgungundlovu District Municipality	179,539	123,372	22,055	145,427	31,204	81%
kz Uthukela District Municipality	117,988	64,681	30,889	95,570	21,764	81%
kz UThungulu District Municipality	160,091	102,243	27,431	129,674	25,749	81%

[49] Provinces noted as: ec = Eastern Cape, fs = Free State, gp = Gauteng, kz = KwaZulu-Natal, lp = Limpopo, mp = Mpumalanga, nw = North West, wc = Western Cape

[50] APR = Annual Program Results

kz Zululand District Municipality	141,756	88,149	26,673	120,493	17,302	85%
lp Capricorn District Municipality	122,526	55,492	43,754	99,246	26,154	81%
lp Mopani District Municipality	106,116	71,846	14,108	95,504	10,670	90%
mp Ehlanzeni District Municipality	299,725	169,041	73,736	242,777	49,949	81%
mp Gert Sibande District Municipality	185,165	89,491	60,493	149,984	53,161	81%
mp Nkangala District Municipality	178,097	74,724	69,535	144,259	48,657	81%
nw Bojanala Platinum District Municipality	197,845	85,412	74,842	160,254	54,551	81%
nw Dr Kenneth Kaunda District Municipality	91,335	46,964	27,017	73,981	13,536	81%
nw Ngaka Modiri Molema District Municipality	110,597	48,075	41,509	89,584	32,056	81%
wc City of Cape Town Metropolitan Municipality	308,407	148,970	100,840	249,810	89,749	81%
Total	**5,257,804**	**2,834,905**	**1,423,916**	**4,346,487**	**1,027,472**	**82%**

Table 4.1.2 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Districts			
Entry Streams for ART Enrollment	**Tested for HIV (APR FY18)**	**Identified Positive (APR FY18)**	**Newly initiated () TX_NEW (APR FY18)**
Adults			
Clinical care patients not on ART*	NA	NA	51,374
HIV+ TB Patients not on ART**	104,552	62,731	59,663
HIV-positive Pregnant Women	636,131	100,489	113,019
Other priority and key populations***	903,872	85,962	75,647
Provider Initiated Testing	7,389,844	704,555	634,099
Home-based Testing	378,871	30,358	27,322
Index Testing	651,722	51,294	46,164
Pediatrics			
Clinical care pediatrics not on ART	NA	NA	NA
HIV Exposed Infants	176,577	397	389
Orphans and Vulnerable Children	271,016	12,045	10,840
Provider Initiated Testing	264,836	10,834	9,751
Home based Testing	95,660	957	861
Index testing	12,038	241	217
Total	**10,885,119**	**1,059,862**	**1,029,346**

Data sources:

***'PITC' section of 'HTC Data Entry' Datapack**

****TB/HIV section of 'Summary & Targets' Datapack**

*****'Other Service Delivery' of 'HTC Data Entry' Datapack**

Table 4.1.3 VMMC Coverage and Targets by Age Bracket in Scale-up Districts				
District[51]	**FY18 Total male population, age 15-29**	**Expected Cumulative Number of Circumcised Men, age 15-29 (end of FY17)**	**FY18 Target VMMC_CIRC, age 15-34**	**FY18 Target Coverage, age 15-34 %**
ec Alfred Nzo District Municipality	166,303	133,011	11,851	80%
ec Amathole District Municipality	197,974	131,657	5,318	>90%
ec Buffalo City Metropolitan Municipality	140,902	117,201	13,049	80%
ec Chris Hani District Municipality	159,211	107,160	15,218	80%
ec Oliver Tambo District Municipality	298,575	218,514	27,849	80%
fs Lejweleputswa District Municipality	124,612	87,150	17,002	>90%
fs Thabo Mofutsanyane District Municipality	152,306	107,431	8,323	80%
gp City of Johannesburg Metropolitan Municipality	840,341	758,438	25,000	>90%
gp City of Tshwane Metropolitan Municipality	580,719	476,209	4,130	>90%
gp Ekurhuleni Metropolitan Municipality	609,042	495,799	10,261	>90%
gp Sedibeng District Municipality	167,464	149,186	6,000	>90%
kz eThekwini Metropolitan Municipality	620,740	444,657	133,077	60%
kz Harry Gwala District Municipality	96,218	65,251	11,410	80%
kz Ugu District Municipality	154,608	98,432	29,709	68%
kz uMgungundlovu District Municipality	206,676	138,076	38,764	80%
kz Uthukela District Municipality	131,582	77,408	23,937	80%
kz Uthungulu District Municipality	166,970	111,843	45,927	80%
kz Zululand District Municipality	168,609	96,080	35,935	80%
lp Capricorn District Municipality	256,388	272,814	5,697	>90%
lp Mopani District Municipality	223,865	223,973	11,887	90%
mp Ehlanzeni District Municipality	318,548	274,484	10,039	>90%
mp Gert Sibande District Municipality	231,250	162,666	15,895	>90%
mp Nkangala District Municipality	307,555	263,719	11,178	85%
nw Bojanala Platinum District Municipality	309,526	214,632	10,814	80%
nw Dr Kenneth Kaunda District Municipality	129,635	98,819	10,935	>90%
nw Ngaka Modiri Molema District Municipality	182,717	146,934	3,539	>90%

[51] Provinces noted as the following: ec = Eastern Cape, fs = Free State, gp = Gauteng, kz = KwaZulu-Natal, lp = Limpopo, mp = Mpumalanga, nw = North West, wc = Western Cape

wc City of Cape Town Metropolitan Municipality	682,880	378,572	28,142	60%
kz Umkhanyakude District Municipality	128,455	116,124	10,769	>90%
Total	**7,753,670**	**5,966,241**	**581,655**	

4.1.4 Target Populations for Prevention Interventions to Facilitate Epidemic Control			
Target Populations	Population Size Estimate (scale-up SNUs)	Coverage Goal (in FY18)	FY18 Target
AGYW + partners	2,144,940	24%	516,975
Miners	85,000	38%	32,000
Inmates	159,331	45%	71,089
FSW	87,472	46%	40,051
MSM	322,052	14%	44,902
Total	**2,798,795**	--	**705,017**

Table 4.1.5 Targets for OVC and Linkages to HIV Services			
SNU	**Estimated # of OVC**	**Target # of active OVC (FY18Target) OVC_SERV**	**Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY18 Target) OVC***
gp City of Johannesburg Metropolitan Municipality	154,382	101,198	101,198
gp City of Tshwane Metropolitan Municipality	90,469	48,381	48,381
kz eThekwini Metropolitan Municipality	221,572	86,989	86,989
ec Buffalo City Metropolitan Municipality	37,922	14,000	14,000
mp Nkangala District Municipality	71,577	24,740	24,740
mp Gert Sibande District Municipality	88,571	25,700	25,700
gp Ekurhuleni Metropolitan Municipality	133,873	33,360	33,360
kz Ugu District Municipality	78,122	19,400	19,400
ec Chris Hani District Municipality	77,033	19,000	19,000
mp Ehlanzeni District Municipality	135,560	31,540	31,540
nw Bojanala Platinum District Municipality	77,076	17,508	17,508
fs Thabo Mofutsanyane District Municipality	69,372	15,361	15,361
lp Mopani District Municipality	81,600	17,915	17,915
kz Harry Gwala District Municipality	55,785	12,200	12,200
kz uMgungundlovu District Municipality	88,618	18,459	18,459
lp Capricorn District Municipality	95,223	19,200	19,200
kz Uthungulu District Municipality	99,107	19,853	19,853

wc City of Cape Town Metropolitan Municipality	96,687	17,900	17,900
ec Alfred Nzo District Municipality	53,226	9,580	9,580
fs Lejweleputswa District Municipality	49,893	8,600	8,600
nw Dr Kenneth Kaunda District Municipality	42,661	7,200	7,200
kz Uthukela District Municipality	75,420	11,355	11,355
kz Umkhanyakude District Municipality	72,192	10,119	10,119
kz Zululand District Municipality	104,278	9,908	9,908
ec Oliver Tambo District Municipality	252,601	22,548	22,548
gp Sedibeng District Municipality	47,649	4,000	4,000
nw Ngaka Modiri Molema District Municipality	68,940	4,975	4,975
ec Amathole District Municipality	83,519	3,800	3,800
Total (27 districts & Umkhanyakude)	**2,602,928**	**634,789**	**634,789**

4.2 Priority Population Prevention and KP Prevention

South Africa's policies and guidelines provide critical direction for priority and KP prevention interventions. These include:

- NSP (2017-2022)
- UNAIDS strategy Fast-Track: ending the AIDS epidemic by 2030, which includes the 90-90-90 targets
- HTS revised policy and guidelines based on WHO's recommendations 2016 (NDoH)
- National PrEP Guidelines with a focus on FSW and MSM June 2016 (NDoH)
- National Condom Distribution Plan (NDoH)
- Health Sector HIV Prevention Strategy 2016
- Draft National Department of Basic Education HIV, STI and TB Policy
- The South African National Sex Worker HIV Plan 2016-2019 (SANAC)
- Draft Lesbian, Gay, Bisexual, Transgender and/or Intersex (LGBTI) Strategy (SANAC)

COP17 will continue to focus on improved condom (male and female) distribution at unconventional community access points including taverns, gas stations, informal shops and retailers, to dispense, promote and empower AGYW and youth to increase condom use. Through DREAMS, PEPFAR SA will expand the supply of female condoms, and emphasize the importance of dual protection with condoms and comprehensive sexual reproductive health and rights education and services to decrease HIV risk, as well as abstinence and behavioral change messages. In COP17 priority prevention will scale up the evidence-based, structured behavioral interventions for HIV prevention and demand creation for the uptake of testing services focused on vulnerable populations (i.e., adolescent girls in school; young women and their male sexual partners, especially those in informal settlements; truckers and clients of FSW), migrant farmers, and male inmates. HTS will be integrated into priority population prevention sites to maximize targeted use of testing, counseling services and linkages to treatment for HIV-positives. In collaboration with the GoSA institutions, including the Department of Basic Education and Department of Social Development, multi-session evidence-based structured curricula to address risk avoidance of GBV and promotion of equitable gender norms to prevent HIV infection will also reach young boys through school-based interventions.

In COP17 PEPFAR will work with the GoSA to expand PrEP services to include AGYW and MSM. In COP16 PrEP focus is on FSW as a component of DREAMS-funded interventions. In COP17, DREAMS/AGYW-focused funding will maintain 3,000 FSWs on PrEP who were initiated in FY16 and FY17 in the five target districts. In COP17 DREAMS/AGYW-focused funding will expand PrEP to 3,735 AGYW in the four DREAMS districts[52]. In COP17 funds will also be used to support PrEP for 8,599 MSM and FSWs and 2,231 AGYW.

KP: In COP17 KP access to and utilization of health services will be a priority. A unique identifier collaboratively developed with NDoH and Global Fund-funded principal recipients will support linkages, tracking, follow-up and de-duplication efforts for FSWs. KP peer navigators who are embedded in sensitized clinics will be deployed to sites that do not have drop-in centers with Nurse Initiated Management of ART (NIMART) trained nurses. In COP17 increasing outreach to hard-to-find populations and strengthening KP linkages to prevention, care and treatment services will be a priority. Social media and regular hotspot mapping will be used to reach new FSWs to increase

[52] PrEP is not planned to expand, but to be maintained in uMkandekude.

outreach, focused testing, and improved linkages to care and treatment. PEPFAR implementing partners will use enrolled nurses[53] as part of mobile outreach units to provide basic health care, testing, counseling and initiating ART and offering of PrEP (for HIV-positive and HIV-negative persons). Mobile units also leverage trained peer educators to conduct HTS. Professional and NIMART-trained nurses will operate from drop-in centers to initiate PrEP and ART for clients. In COP17, implementing partners will also focus on improved and expanded screening and treatment for STIs among FSWs and MSM, including those who are on PrEP.

In coordination with NDoH, SANAC and other multi-sectoral partners, in COP17 PEPFAR will support standardized and piloted programs nationally focused on MSM and inmates. Project Boithato, an evidence-based program grounded upon Mpowerment[54] focuses on young MSM with the provision of prevention, HTS, and linkages to treatment. Social Network Strategy (SNS), PrEP, STI prevention and STI presumptive treatment will be piloted with the Boithato program in Mpumalanga in COP16/17 and rolled out to all MSM sites in COP17. In collaboration with NDoH, DCS and SANAC, more than half (55%) of inmates will be reached with structured, peer-based prevention interventions (STEPS). These interventions will be informed and strengthened by a situational analysis conducted with NDoH and DCS in correctional facilities to determine rates of HIV seroconversion in prisons, STIs, hepatitis, and high risk sexual and injecting behaviors. In COP17, in collaboration with NDoH and PDoHs, an HIV prevention program accompanied by HTC, linkages/provision of ART will be provided to PWID. These activities will be complemented through NDoH and Global Fund funding. During COP17 an integrated biological and behavioral survey (IBBS) in two sites in collaboration with NDoH will support further development of the PWID program.

In COP16 and into COP17 PEPFAR with continue to work with the GoSA and implementing partners to have joint management sessions focused on performance monitoring. These sessions will use a partner monitoring tool, through regular check-ins (by emails, calls, and meetings), monthly site visits and reporting. Emphasis will be on improving linkages between prevention and treatment services.

4.3 VMMC

VMMC targets are focused in districts with HIV-burden with a goal to achieve 80% coverage of males 15-34 years by the end of FY18. While the GoSA's national VMMC program targets 15-49 year old men, and PEPFAR supports its goals, PEPFAR SA focuses its targets to achieve the most immediate reduction in HIV incidence by prioritizing circumcision of older adolescent and young adult males (15-34 years).

Modeling has also shown that targeting this age group is the most cost-effective in terms of infections averted. Eleven of the 27 focus districts are expected to reach at least 80% coverage of males 15-34 years by the end of FY17, with an additional 13 districts reaching 80% coverage by September 2018. Once 80% coverage is reached, with the GoSA concurrence PEPFAR SA will extend the VMMC program to adolescent boys 10-14 years of age.

By the end of FY16, PEPFAR has contributed 1.6 million VMMCs, in support of GoSA's national VMMC total of 2.8 million (approximately 57%). In COP17 PEPFAR will continue to assist the GoSA to scale

[53] Trained Enrolled Nurses are used rather than more expensive professional nurses for mobile outreach.
[54] Mpowerment is a model HIV prevention program that has been specifically designed to address the needs of young gay and bisexual men.

up the national VMMC program through planning, coordination, and implementation including advocacy, communication, and social mobilization. PEPFAR will continue to support the WHO-recommended minimum package of services in public, private and non-governmental facilities in urban and rural communities with low rates of VMMC coverage and high HIV prevalence. PEPFAR will continue to ensure that external quality assurance (QA) and continuous quality improvement (CQI) activities are routinely conducted. VMMC services will also address harmful male norms and behaviors that may promote high-risk sexual behaviors, limit access and/or adherence to HIV prevention services, or directly or indirectly contribute to GBV. Integration of or referral/linkage to other men's health services and programs that promote gender equitable norms with VMMC services will be reinforced.

In COP17 PEPFAR will prioritize roll out of innovations to increase follow-up rates and explore ways to recruit older men for VMMC services. PEPFAR will support the NDoH in implementation of a comprehensive and cohesive national demand creation strategy for VMMC. PEPFAR implementing partners will develop tailored messaging and demand creation to better reach different age groups within the 15- to 34-year-old target audiences, and will work with local community and traditional leaders to ensure VMMC can serve their constituents while preserving dignity and tradition. In COP17 PEPFAR will also provide technical assistance through UNICEF to support policy discussions with the GoSA about a sustainable approach to Early Infant Male Circumcision (EIMC).

In COP17, PEPFAR will continue to support the national VMMC program with new strategic information tools, including an online geographic information system (GIS) and site capacity utilization monitoring for more accurate geographic and age targeting and efficient resource allocation. PEPFAR will also roll out innovative training methods to expand the number of VMMC providers in SA, including a hybrid of online and practical training in the VMMC procedure. In COP17 PEPFAR will actively manage partners through monthly performance and program monitoring to ensure that the PEPFAR contribution to SA's ambitious target for VMMC is achieved.

4.4 PMTCT

SA has made great strides in prevention of mother-to-child transmission (PMTCT) of HIV. There was high coverage of HIV testing and ART above 95% for HIV-positive pregnant women in COP15/FY16. SA implements Option B+ with additional critical interventions such as VL monitoring of pregnant women already on ART at first antenatal clinic (ANC) visit; every three-month VL monitoring of newly diagnosed pregnant/breastfeeding women; birth polymerase chain reaction (PCR) testing; and repeat PCR testing at 10 weeks, 18 weeks, and ≤ 18 months. SA has reached a point where elimination of pediatric HIV infection is within reach. Instead of applying for WHO pre-validation for dual elimination of mother-to-child-transmission of HIV and congenital syphilis, the GoSA, PEPFAR, and other development partners have developed the "Last Mile Plan (2016-2021)," which focuses on reducing the leakages in the PMTCT cascade.

Despite the successful implementation of the PMTCT program with MTCT rates < 2% at 6 weeks and < 5% for the final transmission rate (UNAIDS 2015), major obstacles still exist. SA is still faced with late HIV diagnosis for pregnant women due to late ANC attendance (<60% at 20 weeks gestation [DHIS 2015]); low coverage for retesting of HIV-negative pregnant women before delivery (66% DHIS 2015); high number of pregnant women with unsuppressed VL; low utilization of DNA PCR testing at birth and at 18 months; low ART coverage for HIV-infected infants < 1 year; high absolute numbers of

HIV infections in infants despite low MTCT rates (absolute numbers >50/100 000 per annual live births); challenges with tracking mother-infant pairs for improved linkage to care, adherence and retention in care and treatment; and weak comprehensive programs for primary prevention of HIV and unintended pregnancies.

Ambitious but feasible programmatic targets for retesting of HIV negative women, early ANC booking, VL completion, and real-time monitoring of PCR-positive infants have been included in district and facility 90-90-90 plans. The PMTCT technical working group reviewed and provided input to the District Implementation Plans (DIPs) during the 2016/17 "annual stock-taking exercise" in 14 of 27 PEPFAR-supported priority districts. Working with NDoH and PDoHs, PEPFAR implementing partners supported the technical development, completion and submission of the Last Mile plans in these districts. In COP17 PEPFAR partners will address some of the health system barriers (e.g.,HRH) by deploying temporary lay counsellors, clinicians, and community workers to improve retesting of HIV-negative pregnant/breastfeeding women, male partner testing, QA of HIV rapid testing, TB screening, increased access to EID testing at birth, adherence, VL monitoring, retention, and linkages to family planning services. In COP17 PEPFAR will continue to support ward-based outreach teams (WBOTs) and other community workers (e.g., through the Mentor Mother program) to improve adolescent services and ANC booking before 20 weeks gestation through awareness raising and demand creation.

In COP17 PEPFAR implementing partners will support SA's Last Mile Plan linked to the DIP 90-90-90 objectives through facility-based QI initiatives; strengthened use of programmatic and laboratory data for real-time monitoring of misdiagnosis and tracking PCR-positive infants; tracking mother-infant pairs using community mother peer support care givers; and building capacity of community-based organizations (CBOs) to strengthen bi-directional referral services. In COP17 PEPFAR care and treatment implementing partners (known as District Support Partners or DSPs) will continue to expand alignment with the OVC and prevention program in the focus districts to strengthen family planning, HIV testing and clinical cascade outcomes of OVC.

4.5 HTS

SA rolled out UTT in September 2016. In COP15/FY16, PEPFAR exceeded its HTC_POS target but achieved only 63% of its TX_NEW target. PEPFAR identified an expected number of HIV-positive test results; however only 63% of these estimated individuals were initiated on treatment. While COP16/FY17 Q1 results show improvements in several districts, the overall poor linkage trend has continued, with 30% of the annual target for HTC_POS having been reached in Q1 while only achieving 19% of the TX_NEW target. In the remainder of COP16 and in COP17 high yield testing strategies will be paired with strengthened linkage to treatment activities to have maximum impact on epidemic control. Roughly 80% of HTS_POS have been identified through facility-based testing (PITC and co-located Voluntary Counseling and Testing). While testing yield in facilities has been high, there have been missed opportunities within facilities resulting from less than universal testing among family planning clients, STI patients, and non-surgical, non-orthopedic patients in adult and pediatric inpatient units. In COP16/FY16, 56.8% of TB patients were HIV co-infected, identifying the critical need that 100% of TB patients be tested for HIV. A major emphasis in COP16, which will be continued and expanded in COP17, is the deployment of linkage and retention officers at PEPFAR supported facilities. PLHIV are given preferential consideration in filling these positions, who then accompany newly diagnosed PLHIV from the testing site to the care and treatment site to accompany individual's treatment initiation. The linkage and retention officers then maintain contact with the patient until they are well established on treatment. In PEPFAR-supported facilities, operating hours will also be expanded to improve access for men, and children and adolescents in schools.

COP17 HTS Service Delivery Package will target the following:

Table 4.5.1 Hard-to-Reach Target Populations and Modalities to Reach Them

Target Population	Modality	Location
Men (40% of HTS target)	➢ Mobile testing: 40% ➢ Index-client model: 20% ➢ VMMC platforms: 20% ➢ Partner notification model: 10% ➢ Private GP model: 5% ➢ Pilot Self-testing: 5%	➢ Mines, farms, employment-seeking spots, inmates
Men (<30) and discordant couples	➢ Mobile testing: 80% ➢ Index case testing: 18% ➢ Self-testing: 2%	➢ High-yield communities and hot spots Initiated at health care facilityANC settings
AGYW	➢ Stand alone: 30% ➢ Mobile testing: 20% ➢ Home-based testing: 15% ➢ Social franchising mode: 5% ➢ School clinics: 5% ➢ Facilities with adolescent-friendly services: 5%	➢ Social networks ➢ In- and out-of-school youth ➢ Higher education institutions ➢ High school clinics
KP	➢ Mobile testing and peer navigation model: 80% ➢ Specialized KP-friendly health services: 20%	➢ Trucking spots
Symptomatic clients including pediatrics	➢ PITC (PMTCT, TB, STI, Outpatient Department, Immunizations (EPI)), Integrated Management of	➢ High volume/ burden facilities

	Childhood Illness, FP, in-patient medical wards): 80% ➢ Index client model: 10% ➢ Partner notification: 10%	➢ PLHIV, TB patients, ART patients

In COP17 PEPFAR will support CBO's, WBOTS, CHW, and (for KPs) peer navigators to serve as community linkage officers to assure PLHIV newly diagnosed in the community are successfully referred to the nearest facility, where the facility linkage and retention officers will ensure enrollment in care and treatment. Men age 25-40 and AGYW are specifically being targeted to address a key mode of HIV transmission. In COP17 other strategies to strengthen linkage will include provision of adolescent-friendly services, fast tracking those newly diagnosed to minimize waiting time, increasing PLHIV access to GPs in the private sector for ART initiation and management, and a mass media campaign promoting UTT and encouraging anyone with an exposure risk to be tested. PEPFAR will continue to support NDoH in the process of operationalizing a unique patient identifier, which will enhance monitoring of patients through the clinical and community cascades. In COP17 PEPFAR implementing partners will assist with its rollout to supported facilities.

In COP17 strategies for optimizing yield from community-based testing will be customized across age/sex bands to maximize effectiveness in identifying and linking to treatment for PLHIV among key and priority populations. In COP16 and continued into COP17 PEPFAR is interrogating its own yield data from multiple testing modalities to determine the most effective testing modalities for specific age/sex bands, as detailed in the Table 4.5.1 above.

In COP17 in all districts, 79% of the overall HTS target will be identified through PITC in health facilities. The hard-to-reach populations as well as the asymptomatic PLHIV not accessing health care services will be targeted through community testing, using index testing as well as mobile services.

In COP17 HTS will focus primarily on identifying <30 year old male and female clients through scaled-up index and partner and mobile testing and linkage to treatment. Based on COP15/FY16 and COP16/FY17 Q1 results, both index and mobile testing had higher yield (8%) than other modalities. These modalities will be effective in identifying PLHIV in the critical age group of 15-24 years. Similarly, MSM programs are focused on young men <30 years. Intensive case finding of men between the ages of 25-40 will be conducted in DREAMS districts to identify the sexual partners of AGYW in those districts. PEPFAR HTS programs will also focus on identifying men through mobile testing, by systematically utilizing prevention and GBV platforms such as community dialogues in saturation districts and link HIV-positive men into treatment. Workplace mobile testing will be scaled-up as well as partner notification at facility level. In COP17 targeted inmate testing, as well as focused programming in mining areas will be intensified.

In COP16 and COP17 PEPFAR will continue monthly meetings with all facility- and community-based partners to review monthly performance data, with a focus on HTC_POS and TX_NEW to identify and address performance gaps with corrective actions. "All partners meetings" will be held to share best practices in reaching the hard-to-reach PLHIV and initiating and retaining them on treatment.

SIMS findings indicate several issues related to HTC Quality (15% red and 30% yellow on QA), as well as red scores (6%) and yellows (9%) for compliance with the HIV testing algorithm. In COP17 PEPFAR will support the NDoH QA program rolled out nationally in both community and facility

settings, including Proficiency Testing (NDoH/NHLS/PEPFAR Lab initiative). The HTS register has been standardized for community and facility settings to ensure compliance with HIV testing algorithms.

4.6 Facility-and community-based care and support

In COP17 PEPFAR will continue to focus on aligning community approaches to the clinical cascade, national adherence guidelines, the UNAIDS 90-90-90 targets, attainment, as well as interventions aimed at improving the quality of life of PLHIV. PEPFAR will support the NDoH strategy to expand its differentiated service delivery model which categorizes distinct packages for new, stable and unstable ART patients as outlined in the National Adherence Guidelines. Through this model, by the end of COP17/FY18, an estimated 1.7 million stable ART patients will have been "decanted" to community drug pick-up points to decongest health facilities and reduce the burden on health workers, allowing more new patients to be enrolled in care. With formal implementation of UTT nationwide and the setting of ambitious TX_NEW targets going forward decongestion of health facilities is critical to achieving epidemic control.

The National Adherence Guidelines were adopted in June 2016 and detail the criteria for decanting. As of end of September 2017 (COP16/FY17 Q1), PEPFAR implementing partners had already achieved 34% of their annual decanting target with 497,008 stable PLHIV decanted to receive multi-month drug supplies at external pick-up points. [Nationwide, more than one million patients on chronic medications (including hypertensives, diabetics, etc.) had been decanted by end of FY17 Q1)]. In collaboration with NDoH and PDoHs implementing partners have scaled-up differentiated models of care that focus on community approaches to dispensing ART, including increasing the number of pick-up points in community settings such as CBOs, NGOs, private pharmacies, and adherence clubs. Implementing partners are also strengthening coordination with the CCMDD system that is responsible for pre-packing and distribution of medicines to the pick-up points. Health facilities are utilizing spaced, fast-lane appointments to ensure expedited ART pick up at facility level as well. Stable patients still require twice yearly assessments by the prescribing clinician at the facility, but by enabling those patients to pick up multi-month drug supplies in the community, facility-based health care providers have more time to focus care on sick PLHIV, those with unsuppressed VL, and those on treatment less than one year, as well as absorb the anticipated number of PLHIV requiring treatment initiation.

In COP17 PEPFAR implementing partners will provide training and mentoring of key linkage and retention personnel at both the facility and community level, consistent with government-led planning. At the facility level, PEPFAR implementing partners are training and deploying linkage and retention officers, as detailed in Section 4.5 above. At the community level, the CHWs cadre and the OVC cadre of Community Care Givers (CCGs) are uniquely positioned to identify and link vulnerable populations to testing and known PLHIV to facility-based services as well as support adherence, initiate and follow-up on referrals, and assist in tracing defaulters. In COP16 PEPFAR is supporting the development of a national training curriculum for CHWs as well as investing resources towards training the OVC cadre of CCGs in counseling and referral to ART. CCGs will also be available during HTS outreach days and linked with clinical focal persons for facilitated referral to ART enrollment. Training and mentoring will be provided through NDoH, Regional Training Centers and PEPFAR implementing partners, and will ensure sustainable skills and competencies within government structures for continued technical guidance, training and mentoring. These efforts will

be further augmented by development of a national referral policy that will standardize bi-directional referrals within health care facilities as well as between community and facility, strengthening linkage and retention, as well as improving access to community-based support services. The unique patient identifier, discussed in Section 4.5 above, will be an essential element of this referral process and its monitoring.

Facility linkages to community care and support services consistently scored poorly in PEPFAR SIMS assessments due to lack of a standardized system to track referrals, services received, and any return to facilities. In COP17 the activities detailed above in conjunction with the finalization of the GoSA's national referral policy and unique patient identifier rollout are expected to address these issues.

4.7 Family Planning/HIV Integration

In COP17, PEPFAR implementing partners will support NDoH and PDoHs integration of services to strengthen broader family planning (FP) and HIV access by encouraging women and couples living with HIV to utilize these services to prevent unintended pregnancies, reduce new pediatric HIV infections, and prevent maternal deaths related to HIV. FP/HIV integration is integral to achieving 90-90-90 across multiple PEPFAR-supported programs including PMTCT, TB/HIV care, care and support, KP services, maternal health, AGYW, and DREAMS. The below interventions are expected to improve FP/HIV integration services:

- Strengthen FP integration within HIV programming for access to voluntary counseling, expanded FP method mix and good quality care services; helping women living with HIV and women in sero-discordant relationships achieve safe conception and pregnancy; and provide an opportunity to identify men and children for HTS and linkage to care and treatment.
- Leverage FP services as an entry point to increase access and acceptability of HTS and TB screening among women and their partners. Given an HIV prevalence among pregnant women of 25%, strengthening HIV testing among women seeking FP services is expected to contribute significantly to HTS_POS and TX_NEW.
- Continued support for FP services as a means of helping to keep women living with HIV adherent to treatment and compliant with VL testing and other health interventions.
- Strengthen collaboration efforts with CHWs and WBOTs to increase access to FP information, voluntary counseling and referrals.
- Utilize FP services as an entry point to integrate gender into care to narrow gender gaps and empower women.
- Continue to support implementation of patient tracking and follow-up tools in order to strengthen referral system for FP.

PEPFAR implementing partners will support FP/HIV integration services through: 1) training and capacity building using the updated National Contraception and Fertility Planning curriculum; 2) improved supportive supervision for CHWs and WBOTs; and 3) provision of FP Information, Education and Communication materials. Additionally, utilization of mHealth mobisites, i.e., MomConnect and B-Wise, has been introduced to promote healthy lifestyles, increase HIV awareness, and create demand for integrated FP/HIV services among young people.

4.8 TB/HIV

Despite continuing declines in the number of TB cases reported in SA since 2012, TB still accounts for 7.2% of all deaths in the country and is the leading cause of death for PLHIV. Increasing numbers of multi-drug-resistant (MDR) TB and extensively drug-resistant (XDR) TB cases further complicates control efforts. The TB/HIV co-infection rate declined from 61% to 57% in 2016. COP15/FY16 results show 95% of TB patients in the 27 PEPFAR-supported districts had a documented HIV status and 83% of TB/HIV co-infected patients had received ART.

The GoSA funds the majority of its TB and TB/HIV programs. In FY16/17 domestic TB funding is via the Provincial HIV/TB Conditional Grants. The remaining funding is from bilateral (PEPFAR, USAID), and multilateral (including GF) donors and private foundations such as the BMGF.

In FY17/18 the NDoH will be in its third year of implementing the TB 90-90-90 strategy. There is political commitment to ensure achievement of these targets. In March 2015 the NDoH, in collaboration with partners, embarked on an unprecedented robust exercise to support districts in the development of district implementation plans (DIPs) in order to effectively monitor the implementation of the TB 90-90-90 strategy. These plans were finalized for implementation at the beginning of South Africa's fiscal year 16/17. The use of cascades and the bottleneck analyses during the development of the DIPs has assisted the NDoH in identifying leakages in the cascades and how these may be minimized. The point of entry to the TB/HIV cascade is through the identification and treatment of TB cases. In FY 16/17 the NDoH will be monitoring primary health care (PHC) clients screened for TB as one of the DIP quality tracer indicators in an effort to increase TB case detection. Undetected TB among PLHIV continues to undermine efforts to control both the HIV and TB epidemics.

In COP17, PEPFAR will continue to work closely with the NDoH, PDoHs and other partners to improve knowledge of HIV status among TB patients from 95% to 99% in all 27 districts supported by PEPFAR. SA currently does not track HIV testing of presumptive TB cases. In COP16 and COP17 PEPFAR will work with NDoH and other partners to develop and test a standard approach to systematically monitor services for presumptive TB cases across the HIV and TB care cascade. This strategy will be piloted in COP17 and is expected to inform future policy.

One of the challenges related to access to ART for co-infected TB patients is that not all TB focal persons are professional nurses and therefore cannot initiate and manage ART. In COP17 PEPFAR will work with NDoH to improve ART uptake among TB/HIV co-infected patients from 83% to 95% in the 27 focus districts and continue support for training of nurses on NIMART. In COP17 additional human resources (HR) support will be provided to facilities experiencing low uptake of ART among TB patients. To address the issue of patient attrition in the event that the TB focal nurse is not NIMART trained, in COP17 PEPFAR will also increase the use of counselors/clinic navigators to support facilitated referrals between TB clinics and ART initiation sites. In COP17, to narrow the gender gap and improve women's access to TB/HIV services, PEPFAR will continue to support expanded entry points by strengthening the integration of TB/HIV services in ANC and PMTCT/MCH clinics.

In COP17 to reduce progression from Latent TB Infection (LTBI) to active TB, PEPFAR will place more emphasis on PT initiation and completion among ART patients. There are currently no data on

Isoniazid Preventive Therapy (IPT) outcomes in SA since this indicator is not part of the national indicator data set (NIDS). In COP17 PEPFAR will work with NDoH and partners to support documentation of IPT outcomes on Tier.net.

Additional TB/HIV activities in COP17 will include:

- Technical assistance provided to strengthen TB/HIV collaborative activities through support for evidence-based, contextualized TB/HIV integration policies, capacity building, and training, mentoring and coaching. The following technical priorities and service delivery package will be supported through technical assistance and direct service delivery in SA supported focus districts:
- Scale-up TB symptom screening for PLHIV at every visit including children, pregnant women, diabetic patients, prisoners, miners and peri-mining communities, including stand-alone HCT centers and community (for decanted patients).
- Update TB/HIV policy (TB/HIV integration manual) using evidence generated from PEPFAR-supported sites.
- Scale-up IPT provision for PLHIV through implementation of demand creation strategies.
- Strengthen implementation and monitoring of TB infection prevention and control (IPC) interventions in communities, congregate settings and health care settings, particularly PHC facilities and hospitals.
- Support development of policies for management of LTBI amongst HCWs.
- HTS for TB patients and presumptive TB cases with immediate access to ART for all co-infected TB patients. PEPFAR SA will support lay counselors to provide PITC services for all patients including TB patients in high-volume sites.
- Targeted support for the implementation of the national integrated HIV and TB information system. PEPFAR SA will deploy data capturers in high-volume sites to fast track roll out of the TB module in Tier.Net.
- Improve initiation of TB second-line treatment for PLHIV who are diagnosed with MDR-TB.
- Maximize TB case finding through household testing and assure HIV testing of those identified TB cases in the household.
- Provide technical assistance to district management and facility staff to implement the NDoH QA/QI approach as an effective strategy for improving the quality of TB/HIV care across the cascade.
- Support institutionalization of TB/HIV cascade analysis at facility and district level to improve tracking of PLHIV screened for TB through diagnosis until treatment initiation.
- Provide technical assistance to improve compliance with the TB diagnostic algorithm and ensure consistent use of GeneXpert as the initial diagnostic test for PLHIV.

In COP17 to further increase the proportion of TB patients with a known HIV status to attain 99% testing rate and increase ART uptake amongst co-infected TB patients and PLHIV completing TB preventive therapy (TPT), PEPFAR will closely monitor partner performance through: review of the entire TB/HIV cascade during SIMS visits, technical review meetings with partners to discuss performance, mitigation strategies monthly reviews, and quarterly joint program progress meetings.

4.9 Adult Treatment

In September 2016, SA adopted policy changes that include UTT for all PLHIV, as well as provision of PrEP to KP such as HIV-negative FSW. COP17 targets and strategies assume full implementation of UTT and same-day initiation nationwide in all of SA's nine provinces. Twenty-one of the 27 priority districts supported by PEFPAR are targeted for saturation in COP17, with the remaining six expected to achieve attainment55 status.

In COP17, PEPFAR will continue NDoH and PDoHs' support for the implementation of UTT and same-day initiation policy through ongoing scale-up in the 27 focus districts. In COP17 PEPFAR will assure that appropriate testing at all facility-based PITC entry points (with particular focus on inpatient units where testing has been inconsistent and not adequately monitored) is maximized. PEPFAR will also continue support of differentiated models of care, targeting 1.7 million stable PLHIV on ART through the CCMDD, GP and community adherence programs.

In COP17 PEPFAR will work with NDoH to identify efficiencies, new strategies and innovations in ART service delivery. In COP17 PEPFAR will support GoSA towards achieving an increase of approximately 1 million PLHIV on ART in the 27 focus districts. PEPFAR will work with NDoH and PDoHs in reconfiguring service delivery approaches to achieve greater efficiency and reduce costs through accelerated implementation of the UTT policy and differentiated care service delivery models for stable ART patients. PEPFAR will also support NDoH and PDoHs through technical assistance and placing human resources through roving mentoring teams, short-term human resources staff support for 3-6 months, and secondments of PEPFAR-funded staff for up to 12 months. Facility-based staff support may include, lay counsellors, linkage officers, peer navigators, nurses and doctors in high-volume clinics with low performance to improve service delivery for HIV-infected patients. PEPFAR will support NDoH and PDoHs to implement standard, high-quality, patient-centered HIV services to optimize the care continuum; reduce intensity and frequency of clinical visits per guidelines for stable ART patients; and support patient-centered models. It is expected that the volume of HIV patients in facilities will decrease as attainment and saturation is achieved and as stable patients are decanted to alterative services delivery including multi-month ARV resupply and community pick-up points. Accordingly PEPFAR funding for seconded facility-based staff will decrease. These efforts will also be aligned with general strategies to mainstream HIV care as a chronic condition.

In COP17 PEPFAR will support advanced planning of supply chain needs for successful decentralization and community drug-delivery models and for adequate buffer stock to ensure less frequent drug pickup; support evidence-based adherence interventions, including community-based cadres, peer counselors, and mobile phone text messages and other phone application reminder systems; promote a choice of ART delivery options such as facility-based fast track and community-led models of ART provision, including community adherence groups (CAGs), community-led adherence clubs, and community drug delivery through the CCMDD where feasible. During COP17 PEPFAR will support clinic-laboratory interface (CLI) activities at the facility level. Activities will include: (1) training of HCWs on specimen and test result tracking; test request form completion (specifically addressing the use of the unique identifier); (2) recruitment of partner-based laboratory coordinators to provide technical assistance to facilities on laboratory-related activities; (specimen

[55] Op. cit. 2 (above)

collection, packaging, storage, transportation, and tracking); (3) QA training; and (4) entering laboratory data onto patient chart and into Tier.net.

In addition, PEPFAR will continue to support the NDoH DIP process as this will serve as the node for planning, management and coordination of HIV programs at the district level, including programs supported by PEPFAR implementing partners. PEPFAR will also continue to support expansion of service delivery platforms through scale-up of HIV service delivery activities in public sector facilities; implementation of innovative/best practice service delivery activities at community level to improve early initiation, active referral and retention in care; support the role of private sector involvement (private health facilities, GPs) in supporting continuum of care activities and intensify targeted/focused trainings essential for 90-90-90. PEPFAR will also intensify synergies and coordination with community-based programs to increase utilization of NDoH, CHWs and WBOTS; engage CBO support for HCT, linkage and retention, and treatment adherence; and work with implementing partners to adopt a district approach of coordination with HIV prevention and OVC programs.

Improving utilization of VL testing is in progress in SA. To date, the program achieved 64% VL coverage and 87% VL suppression among patients who had VL done. However, there are significant variations in completion and suppression across districts. Although there is high VL suppression among the VL done, documented VL coverage is low.

There is evidence of VL underreporting, highlighting issues related to data flow and quality. A study in SA, conducted by NHLS, indicates more VL were completed than reported in Tier.net. There are red SIMS Core Essential Elements (CEEs) for poor VL documentation across multiple districts and partners. In COP17 data capturers will be placed in facilities to support capturing VL and other patient data in Tier.net.

In COP17 PEPFAR will continue support to SA's efforts to scale up VL completed and reported with a goal of the routine use of VL completed and reported for all ART patients. Experience to date suggests that existing VL platform/equipment is underutilized with 40% or more testing volume that could be done by existing platforms with strengthening the pre-analytic phase within the lab, appropriate planning, and adequate staffing. In COP17 PEPFAR will work with the NHLS to increase testing capacity and efficiency of existing platforms by strengthening the pre-analytical phase within the lab; and improving efficiency of laboratory networks (by improving specimen handling, tracking, transport networks, and results return to clinic, entry into patient chart, and into Tier.net and educating patients, clinicians, and laboratorians on the importance of routine VL testing and improved monitoring). In addition, in COP16 and in COP17 PEPFAR will continue focused communication efforts to improve patient-level understanding of VL and the importance of achieving viral suppression to improve health as well as to prevent transmission. VL reports serve as a proxy of success at the district level for achievement of large-scale community viral suppression.

4.10 Pediatric Treatment

In SA an estimated 340,000 children under the age of 15 are living with HIV (UNAIDS 2014). Under 15- year-old ART coverage is 51.7% (UNAIDS, 2016). Despite reduction in HIV incidence to <2% at birth among exposed infants through the PMTCT program, there are infected older children who remain untested and present only when symptomatic. Most of the estimated children living with HIV

(243,744; 71.7% of total) reside in the 27 PEPFAR-supported districts; and 135,650 or 55.7% of them are on ART as of COP15/FY16, (slightly higher coverage in the 27 districts).

Late diagnosis of HIV has a significant impact on the associated morbidity and resultant mortality among these children, besides the debilitating neurological effects resulting in motor abnormalities and cognitive dysfunction. In COP17 PEPFAR with NDoH, PDoHs and implementing partners will expand innovative methods to identify these children before the infection has had a significant effect on their quality of life. In COP17 PEPFAR plans to support case finding initiatives with high yield including testing family members of index cases either at the facility or at patients' homes; improving OVC screening; and ensuring all children and adolescents presenting at school health services and health facilities are screened using age-appropriate algorithms. In COP17 PEPFAR targets linking more than 90% of identified <15 year old PLHIV children to initiation of ART.

In COP17 PEPFAR will work with the NDoH and other partners to enhance contact tracing using the index patient by testing all family members including children of any known HIV-positive case. PEPFAR will also expand targeted testing/PITC amongst OVC using the screening algorithm developed by the OVC TWG, as well as amongst children and adolescents attending clinics for recurrent lower respiratory tract infections or gastroenteritis, TB, malnutrition, or developmental delay. The IMCI testing algorithm will be used for screening children <5 attending well-baby clinics. Primary caregiver (parent, grandparent, other relative) and child discussions related to HIV and HCT will be addressed through the KIDZ Alive program disclosure guidelines. These tools are being rolled out by NDoH in COP16. The guidelines help HCWs and caregivers address issues around testing, disclosure, ART, and adherence to treatment. Both interventions will help assure safe and child-friendly spaces, increased uptake of HCT and case finding, and improved retention in care and adherence to treatment.

One of the gaps identified via SIMS is that primary care clinics often lose contact with new mothers post-delivery, especially if the delivery was at a district hospital; and even when they retain contact, lower-level PHC facilities often are unaware of the child's birth PCR/HIV test results. During COP17 PEPFAR will support NDoH and PDoHs to expand the use of CHWs to ensure that all HIV-positive as well as HIV-negative mothers are linked back and retained into care post-delivery. HIV-positive mothers will be retained on treatment and their infants tested regularly especially if the mother is breastfeeding. HIV-negative mothers will be retested post-delivery and at regular intervals while the mother is still breastfeeding.

TB screening and diagnosis continues to be a challenge among children due to inconsistencies in obtaining clinical history and specimens from children. Continued supervision and mentoring of clinic staff by facility-based partners will help improve TB case finding in children. Pediatric growth monitoring and absence of resultant referrals remain a challenge identified during SIMS visits. To address this gap, PEPFAR is working with the NDoH and PDoHs and implementing partners to ensure that all facilities have access to appropriate tools such as mid upper arm circumference (MUAC) tapes for screening patients. PEPFAR is also supporting NDoH and PDoHs efforts to provide consistent use of pediatric clinical registries.

Strengthening community linkages is critical for the three 90-90-90 goals as well as preventing new HIV infections in infants. Using CHWs strategically can help timely access to treatment as well as

adherence and retention in care. SA has not yet adopted differentiated care models and CCMDD[56] for younger children who need to be followed regularly for weight monitoring and resultant dose changes; however, PEPFAR is recommending NDoH to adopt a differentiated model of care for children and adolescents who are stable on treatment.

Regular VL monitoring is key to ensuring that children on ART are suppressed and retained on treatment. VLs among children are often delayed or not done due to inexperience in pediatric phlebotomy. In COP17 PEPFAR will use roving teams to provide direct service delivery and mentorship to clinic staff to address pediatric ART initiation bottlenecks as well as to address virologic failure in children. Empowering facility nursing staff on when regimens need to be changed and when to refer children for assessments to the hospital will make a significant impact on the quality of care. In COP17 PEPFAR will also be working with NHLS to ensure that dry blood spots for VL are approved and available for children and adolescents.

In COP16 and continuing in COP17, PEPFAR is working with NDoH to support a Pediatric HIV Drug Resistance survey among children with virologic failure on ART. The survey will help ensure that appropriate second-and third-line regimens are used. In COP16 and 17 PEPFAR SA is also focusing on enhancing sensitized adolescent and youth-friendly clinic services including late-hour and weekend clinic services to accommodate school/university students; sensitive HCT; nondiscriminatory sexual and reproductive health services; support groups; availability of chronic medication dispensation systems for older children stable on ART; as well as transition into adult health services. In COP17 PEPFAR also intends to support NDoH efforts to empower HIV-positive adolescents through IEC materials and improve demand creation for treatment and VLs through social media platforms.

4.11 OVC

According to UNAIDS estimates (2015), about 2.1 million SA children aged 0-17 years were orphaned due to AIDS. The 2011 Census estimates there are 3,344,832 orphans aged 0-17 years, with about 78% located in the 27 focus districts. These data reflect all orphans and not only orphaned children attributed to HIV/AIDS; these data also do not include children made vulnerable by HIV/AIDS (e.g., those living with HIV or with HIV-positive caregivers). In COP17, PEPFAR in collaboration with the National Department of Social Development (NDSD) and implementing partners will provide services to 634,789 OVC. This target is based on OVC burden, HIV prevalence, APR 2016 data, partner capacity and Expenditure Analysis data.

OVC are at increased risk of HIV infection and efforts to increase access to HTS and other health and social services that address the enabling factors essential to successful prevention, care, and treatment can contribute directly to 90-90-90 targets and epidemic control. In COP17 all PEPFAR OVC program beneficiaries (<18 years old) will have their HIV status reported to the implementing partners (including status not reported), disaggregated by status type. In COP17 in coordination with NDSD, PDSDs and implementing partners, community/clinic linkages will be facilitated and improved, including counselling (including family-centered disclosure) and referrals, as well as expanded quality case management.

Through effective case management, household visits, and improved use of data and targeting, OVC implementing partners will identify the most vulnerable children (including AGYW) and provide one-on-one support that empowers them to stay in and progress in school; access health services and grants; be adherent and retained in care; and reduce abuse and prevent new infections. Through DREAMS/AGYW focused funding, OVC partners will support the GoSA's plans to provide school-based interventions, parenting/caregiver programs, socio-economic empowerment, social asset building, and youth-friendly sexual and reproductive healthcare (including linkages to health services and provision of HTS) that will empower AGYW, strengthen families and mobilize communities. In COP17, PEPFAR implementing partners will increase the delivery of an evidence-based package of services to beneficiaries 15-17 years of age especially girls. This includes a new program which seeks to expand youth health and development programs for OVC ages 15-17 in three saturation districts. Implementing partners will also prioritize risk avoidance strategies for girls 10-14 years to ensure that they stay HIV-negative.

In COP16 PEPFAR was awarded Plus Up funding for COP16 GBV activities. These child protection and GBV activities aligned with NDSD will be integrated into COP17. In addition, the portfolio will have greater focus on prevention of GBV and improved linkages to post-violence care and PEP as well as using post-violence care facilities as an entry point to maximize the potential to increase uptake of HIV interventions.

Strategic investments in critical social systems strengthening will continue through coordination with NDSD and implementing partners that provide support to NDSD and PDSDs to address the social and structural barriers that increase the vulnerability of OVC to HIV. These activities include: strengthening the social welfare workforce serving children (including improved child protection interventions to prevent and respond to neglect, violence and exploitation of children and adolescents); supporting the national rollout of social behavior change activities; and supporting the NDSD's Community-Based Information Management System (CBIMS) electronic data management training.

4.12 Addressing COP17 Technical Considerations

Increased focus on prevention and care services for under 30 year-olds:

- Specific DREAMS prevention activities to be expanded to 22 sub-districts in non-DREAMS priority districts, supporting the GoSA's She Conquers prevention campaign.
- PEPFAR implementing partners have scaled up focus and support for AGYW in all 27 priority districts.
- School health clinics to introduce sexual reproductive health (SRH) services including HIV testing.
- OVC programming to focus on the 10- to 24-year-old age band, stressing reproductive health education and postponement of sexual debut for 10-13 year olds and assuring HIV testing for 14- to-24-year olds following sexual debut; Community Care Givers to accompany those testing positive to enroll in treatment.
- PrEP currently available only for FSWs; PEPFAR to fund commodities and expansion to MSM and vulnerable AGYW that will support GoSA with additional demonstration projects.
- PEPFAR to fund training and implementation of post-violence care.
- VMMC to improve demand creation and targeting of 15-to-29-year old age band.

- PEPFAR supports the NDoH's *Phila* public health messaging campaign, a major aspect of which is promoting condom use and responsible male sexual practices. PEPFAR continues to support partners providing testing and treatment services to prison inmates, migrant farm workers and miners.

Mix of HIV testing modalities to improve testing coverage, yield & efficiency:
PEPFAR has interrogated its own yield data from multiple testing modalities to determine what appear to be the most effective testing modalities for specific age/sex bands. In COP16 and continued into COP17 strategies for optimizing yield from community-based testing will be customized across age/sex bands to maximize effectiveness in identifying and linking PLHIV to treatment among key and priority populations. Both index and mobile testing modalities had higher yield (8%) than other modalities. In COP17, HTS will focus primarily on identifying <30 year old males and females through scaled-up index and partner testing and mobile testing and link them to treatment.

- Identification of men (40% of HTS COP17 target) through:
    - Index case identification as noted above;
    - Mobile testing through systematic utilization of PP-PREV and GBV platforms such as community dialogues in saturation districts and link them to HIV treatment;
    - Workplace mobile testing will be scaled-up and target male-dominated industries for the 25- to 40-year old age group;
    - Facility-based services including Pilot partner notification for partners of PMTCT clients; STI and TB/HIV clients;
    - Targeted inmate testing nationally, as well as intensified mining programs; and
    - Saliva-based self-testing currently undergoing certification for use in SA. During COP16, PEPFAR is providing NDoH technical assistance to development self-testing national guidelines. In COP17, use of self-testing will be piloted especially to improve partner testing of ANC clients.

- Identification of AGYW in and out of school through a mix of targeted HTS modalities including:
    - Stand-alone centers;
    - Mobile testing;
    - Home-based testing; and
    - Social Franchising model and facilities with adolescent-friendly clinics.

Currently, women seeking FP services are not routinely tested for HIV. The resulting positivity rate is expected to approach that for pregnant women (13.3% newly positive in COP16/FY17 Q1). In COP17 PEPFAR will support NDoH and PDoHs to scale up HIV testing of FP clients.

As highlighted earlier in the SDS, throughout COP15/FY16 and continuing into COP16/FY17 Q1, TX_NEW has significantly under-performed in comparison to HTC_POS. To address the ongoing challenge in linking newly diagnosed PLHIV to treatment, the following mix of linkage strategies will be implemented to achieve 90% linkage in COP17:

- Expand deployment of linkage and retention officers at high-volume facilities to accompany newly diagnosed PLHIV from the testing site to the care and treatment site within a facility for same-day initiation;

- Provide adolescent-friendly services and fast tracking those newly diagnosed to minimize waiting time;
- Increase PLHIV access to GPs in the private sector for ART initiation and management; and
- CBOs, CHWs, and peer navigators for KPs to serve as community linkage and retention officers to ensure newly diagnosed PLHIV are successfully linked to the nearest facility for same-day enrollment in care and treatment.

Improved Linkage, Retention, and Viral Suppression:
Though UTT is official policy, there is not clear guidance regarding same-day ART initiation. At the national level, PEPFAR supporting NDoH with technical assistance to develop eligibility criteria for same-day initiation, enhancing both linkage and retention. In COP17 PEPFAR will:

- Emphasize the implementation and scale up of the use of a Unique Patient Identifier (called National Health Identifier in the Technical Considerations), which will reduce loss to follow-up (LTFU) by at least 30% by being able to account for silent transfers and enable better tracking of patients across the treatment cascade and across care facilities.
- Provide technical assistance to NDoH in revising post-test counseling messaging for HIV-positive persons, emphasizing the importance of early treatment to improve linkage.
- Increase funding for facility-based linkage and retention officers.
- Fund national media campaigns to highlight UTT, intended to increase demand among known HIV-positives individuals who have not sought care and encourage testing of those with potential risk.
- Expand adolescent, youth friendly services and clinic office hours to increase enrollment of PLHIV < 30 years old in care and treatment and help retain them in care. Peer support groups providing psychosocial support will be embedded in the routine service package.
- Launch and implement an e-Health App to improve adherence and retention.
- KP-friendly service delivery sites—that have been developed and managed by Non-governmental organizations (NGOs)—are now providing ART. Currently five FSW sites are providing PrEP and ART in COP16. While FSW are highly mobile and at increased risk of being LTFU, strengthened peer navigation and education will help assure ongoing follow-up across facilities. The patient ID for KP discussed above will also assist. In COP17, 11 sites will support FSWs and three will serve MSM.
- Among PMTCT clients, there is inadequate monitoring through end of breast feeding and poor recording of infant status post-cessation of breast feeding. Mentor mother peer support groups will be enhanced in COP17 and utilized to retrieve defaulters.
- VL performance varied significantly across districts in COP15/FY16, with VLD/TX_CURR ranging from 90% to 40%, median 63%. Among those tested suppression rates ranged across districts from 94% to 73%, median 85%. Only two districts had a suppression rate <80%. Bottlenecks in clinical-laboratory interface have been identified as root causes of poor VLD performance. One important bottleneck is inadequate results management and documentation in clinics. PEPFAR SA is addressing this by funding facility-level data capturers through its partners and mentoring by facility-based partners. The NHLS with PEPFAR funding will utilize the ECHO platform, developed in the U.S. for assisting rural health care providers in management of chronic disease, to train HCW in proper documentation of VL results. Additionally, PEPFAR implementing partners provide on-site mentoring on treatment failure. A target of 90% for TX_VIRAL has been set for COP17.

Ensuring Access to Quality, Sustainable HIV Delivery Systems:

- In COP15/FY16 the GoSA implemented differentiated service delivery models that allowed stable patients to be decanted to community-based drug pick-up sites for dispensing of multi-month prescriptions, with visits to facility-based health care provider decreased to twice yearly. In COP15/FY16 and through COP16/Q1FY17, approximately 497,008 PLHIV have been decanted to these alternative service delivery sites.
- In COP17, PEPFAR will strengthen sustainability by funding development of curriculum for CHWs that will enhance their capacity to assess status of stable patients decanted to community and link those needing medical attention back to facility.
- PEPFAR's facility-support partners will subcontract with PLHIV organizations to identify and train PLHIV as linkage and retention officers to be placed in supported facilities.
- PEPFAR staff will provide TA in developing a tool for monitoring retention of PLHIV decanted to alternative community-based sites.

4.13 Commodities

Currently there are no commodities stock-outs or projected funding gaps; however, with COP17's more aggressive attainment and saturation targets PEPFAR is working closely with the NDoH to ensure that the necessary commodities are available. PEPFAR is also speaking with the GF about these issues, as it may be able to assist if there are short-term bridging needs for commodities. PEPFAR and NDoH are monitoring this closely and follow-up with the Office of the Global AIDS Coordinator (OGAC) as needed.

4.14 Collaboration, Integration and Monitoring

In COP17, PEPFAR will support the GoSA to more holistically monitor the HIV/AIDS clinical cascade from diagnosis, linkage to care and treatment, retention on treatment, and viral suppression. Data from this monitoring will be used to identify areas of deficiency (e.g., leakage along the cascade) by location and population for immediate action.

Specific activities that will be continued or initiated in COP17 include:

- Support to the DIP process. These DIPs are rigorous plans and M&E systems that are designed to achieve 90-90-90 at the district level. Additionally, provincial HIV conditional grants issued by NDoH will be tied to DIPs.
- In coordination with the GoSA, implementation of the partner and district program monitoring strategy. This will include monthly and quarterly routine review of SA and PEPFAR data at the sub-national and partner levels to monitor performance and impact.
- Support to key SA information systems (e.g., Tier.Net, DHIS) that are used to capture patient- and program-level data along the continuum of HIV services. Support will include: data quality and analysis support at the national- and sub-national levels; enhancement of Tier.Net to include the HTC, pre-ART, TB, adherence club, and maternal/child health modules; and movement to a web-based DHIS reporting system to facilitate more timely data entry and analysis.

- Utilizing the existing reporting systems, establish HIV case-based surveillance (pending findings from the COP16-supported pilot) for more 'real-time' monitoring of the clinical cascade. Support the implementation of the unique patient identifier system (Health Patient Registration System, HPRS) to better monitor patients across services and service-delivery points.
- In addition to host country systems, PEPFAR will continue to collect critical program data and custom indicators (e.g., DREAMS, decanting, direct service delivery/technical assistance) monthly to monitor partner performance in real-time.
- PEPFAR will routinize analytics of routine and custom indicators to share with the GoSA, implementing partners, and other stakeholders.
- PEPFAR will continue to support Best Practices meetings, partner meetings and bilateral USG/GoSA meetings to foster on-going collaboration, learning, and adapting.

5. Program Activities in Sustained Support Locations and Populations

In COP17 PEPFAR is supporting SA to achieve attainment in six districts and saturation in 21 districts. In COP18 it is envisioned that PEPFAR will have sustained and attained districts and specific support interventions to assist the NDoH and provincial departments of health to maintain saturation and attainment.

6. Program Support Necessary to Achieve Sustained Epidemic Control

During COP17 PEPFAR will continue to address the three programmatic gaps and two priority policies identified in COP16.

Programmatic Gaps:
1) Documented VL Completion
2) Facility/Community Continuum of Care
3) Targeted and Data-Driven Service Delivery to KPs

Priority Policies:
1) UTT[57]
2) New and Efficient Service Delivery Models[58]

In SA, all direction, guidance and decisions are set at a national level and implemented at the provincial, district and facility levels. The provinces are administratively responsible for the planning, management, implementation and monitoring of all government services. For example, decisions for filling vacant positions related to test and treat and new service delivery models as well as the operationalization and implementation of policies such as UTT are based on provincial mandates. In certain instances, national and provincial departments of health lack adequate numbers of staff for the successful implementation of NSP (2017-2022) and PEPFAR priorities. PEPFAR must align with the national and provincial structures and systems to ensure that joint goals may be met. COP17 continues support in building capacity and strengthening HR and systems at national and provincial levels to ensure success of NSP and PEPFAR program priorities at the district and facility levels. To strengthen monitoring of systems investments, annual benchmarks have been included in COP17 to measure progress of activities towards the three-year outcomes described in the COP16 Systems Budget Optimization Review (SBOR). Through extensive consultation with stakeholders and robust interagency discussion, PEPFAR confirmed which activities continue to be relevant and will be continued, with a limited number of activities modified or discontinued.

6.1 Critical Systems Investments for Achieving Key Programmatic Gaps

PEPFAR reviewed the COP16 SBOR and confirmed the key programmatic gaps to achieving 90-90-90:

Documented VL Completion

Facility/Community Continuum of Care

Lack of targeted and data-driven service provision to KPs

[57] See Appendix 3 for Tables 6.1., 6.2., and 6.3
[58] i.e. Implementation of the NDoH Adherence Guidelines

Documented VL Completion

PEPFAR supported NHLS, NDoH, PDoHs to increase the number of VL done (TX_VIRAL) by almost 50% from 1,074,447 to 1,502,691, but documentation of VLs completed still remains a critical gap for clinical management of patients and enrolling patients on new and efficient service delivery models (e.g., CCMDD, Community Adherence Clubs). Two of the three systems barriers to be addressed in COP16 remain unchanged for COP17: (1) Limited HIS capacity; and (2) Limited capacity of HRH. The third systems barrier has been modified to (3) Weak VL cascade specifically before and after the Laboratory (Clinic/Lab interface). The change reflects a more strategic direction in resolving the clinic/lab interface.

Activity changes include: the HIS activities have been refined to be more strategic, increase accountability, and yield immediacy of impact. HRH investments have been modified to reflect the changing direction put forth in the NDoH HRH Strategy currently under development, and PEPFAR has discontinued funding for an activity to pilot decentralized testing, as the activity is completed with GF resources.

Facility/Community Continuum of Care

PEPFAR is working with NDoH and PDoHs to bridge the gap between HIV-positive test results and HIV services—an early outcome of this shift is increasing the treatment linkage proxy indicator (HTC_POS/TX_NEW) from 65% in COP15/FY16 to 74% in COP16/FY17, even before test and start was fully implemented. The four systems barriers from COP16 remain unchanged: (1) Lack of a bi-directional referral system; (2) Limited HIS capacity; (3) Limited capacity of WBOTs and community cadres; and (4) Linkages between services provided by the public sector and CBOs/faith-based organizations (FBOs). In addition, in consultation with external stakeholders, PEPFAR SA has included high LTFU as a fifth systems barrier.

Activity changes include: the HIS activities have been refined to be more strategic, increase accountability, and yield immediacy of impact; support to WBOTs has been modified to support the new structure and scope of WBOTs, which includes a more focused role in UTT and new and efficient models of service delivery; and increasing support to the NDoH-led National LTFU Plan.

Targeted and data-driven service provision to KPs

As epidemic control is pursued, there is a need to understand the micro-epidemics' contribution to the general population epidemic. PrEP guidelines have been established to initiate FSWs on PrEP. PEPFAR SA continues to address the four systems barriers identified in COP16: (1) Limited surveillance of KPs; (2) Limited exchange of routinely collected information between the public sector and organizations serving KPs; (3) KPs experience stigma and discrimination when accessing services at public health facilities; and (4) Limited systems in place for PEP and PrEP provision.

Activity changes include: collecting and utilizing more routine data for size estimates, mapping, and cascade analysis; expanding PrEP eligibility to MSM and AGYW; purchasing of PrEP drugs and labs; and implementing demand creation activities for PrEP, particularly for FSWs and MSM. Demand creation will be done through peer education and support.

6.2 Critical Systems Investments for Achieving Priority Policies

PEPFAR reviewed systems barriers inhibiting UTT and new and efficient service delivery models from the COP16 SBOR. Two major successes in the past year include the GoSA's announcement of UTT in September 2016 and over 1 million patients enrolled in CCMDD.

The systems barrier related to the UTT policy has shifted to operationalizing same-day initiation. Furthermore, the systems barrier related to HRH personnel shortages has been modified to a shortage of HRH capacity, including training needs. Major activity-level changes include: the completion of the Health Labor Market Analysis and graduation from hiring foreign-qualified doctors as a stand-alone activity, which will be integrated into provincial and district level support; a substantial increase to the CCMDD program, in terms of activities and resources; and, increased investment in HRIS including the Knowledge Hub, Workforce Indicators of Staffing Needs (WISN) assessments and PERSAL (salary management) systems.

6.3 Proposed system investments outside of programmatic gaps and priority policies

PEPFAR also reviewed the systems investments outside the programmatic gaps and priority policies. All activities have been refined to align with 90-90-90 and epidemic control. Major changes include the graduation of TB training interventions which have been handed over to universities for continuation; alignment of surveillance activities to the National Strategic Plan for Surveys and Surveillance; and elimination of site-level activities included in the COP16 SBOR.

APPENDIX A

A.1 and A.2 Sub National Unit (SNU) Prioritization

District	COP 15 Prioritization	APR16 Achievement	COP16 Prioritization	Expected Achievement By APR17	COP17 Prioritization
gp City of Johannesburg Metropolitan Municipality	ScaleUp Sat	47%	ScaleUp Sat	81%	1_Attained
gp Ekurhuleni Metropolitan Municipality	ScaleUp Sat	51%	ScaleUp Sat	73%	1_Attained
kz eThekwini Metropolitan Municipality	ScaleUp Sat	56%	ScaleUp Sat	84%	1_Attained
kz uMgungundlovu District Municipality	ScaleUp Sat	69%	ScaleUp Sat	71%	1_Attained
kz Zululand District Municipality	ScaleUp Agg	62%	ScaleUp Agg	80%	1_Attained
lp Mopani District Municipality	ScaleUp Agg	68%	ScaleUp Agg	88%	1_Attained
ec Alfred Nzo District Municipality	ScaleUp Agg	49%	ScaleUp Agg	70%	2_Saturation
ec Amathole District Municipality	ScaleUp Agg	43%	ScaleUp Agg	59%	2_Saturation
ec Buffalo City Metropolitan Municipality	ScaleUp Agg	47%	ScaleUp Agg	62%	2_Saturation
ec Chris Hani District Municipality	ScaleUp Agg	44%	ScaleUp Agg	59%	2_Saturation
ec Oliver Tambo District Municipality	ScaleUp Agg	49%	ScaleUp Agg	58%	2_Saturation
fs Lejweleputswa District Municipality	ScaleUp Agg	55%	ScaleUp Agg	76%	2_Saturation
fs Thabo Mofutsanyane District Municipality	ScaleUp Agg	57%	ScaleUp Agg	69%	2_Saturation
gp City of Tshwane Metropolitan Municipality	ScaleUp Agg	44%	ScaleUp Agg	63%	2_Saturation
gp Sedibeng District Municipality	ScaleUp Agg	53%	ScaleUp Agg	63%	2_Saturation
kz Harry Gwala District Municipality	ScaleUp Agg	59%	ScaleUp Agg	78%	2_Saturation
kz Ugu District Municipality	ScaleUp Agg	61%	ScaleUp Agg	74%	2_Saturation
kz Uthukela District Municipality	ScaleUp Agg	55%	ScaleUp Agg	70%	2_Saturation
kz Uthungulu District Municipality	ScaleUp Agg	64%	ScaleUp Agg	72%	2_Saturation
lp Capricorn District Municipality	ScaleUp Agg	45%	ScaleUp Agg	67%	2_Saturation
mp Ehlanzeni District Municipality	ScaleUp Agg	56%	ScaleUp Agg	72%	2_Saturation
mp Gert Sibande District Municipality	ScaleUp Agg	48%	ScaleUp Agg	60%	2_Saturation
mp Nkangala District Municipality	ScaleUp Agg	32%	ScaleUp Agg	61%	2_Saturation
nw Bojanala Platinum District Municipality	ScaleUp Agg	43%	ScaleUp Agg	61%	2_Saturation

nw Dr Kenneth Kaunda District Municipality	ScaleUp Agg	51%	ScaleUp Agg	74%	2_Saturation
nw Ngaka Modiri Molema District Municipality	ScaleUp Agg	43%	ScaleUp Agg	60%	2_Saturation
wc City of Cape Town Metropolitan Municipality	ScaleUp Agg	84%	ScaleUp Agg	59%	2_Saturation
ec Cacadu District Municipality	Ctrl Supported	39%	Ctrl Supported	0%	3_Ctrl Supported
ec Joe Gqabi District Municipality	Ctrl Supported	48%	Ctrl Supported	0%	3_Ctrl Supported
fs Fezile Dabi District Municipality	Ctrl Supported	48%	Ctrl Supported	2%	3_Ctrl Supported
fs Xhariep District Municipality	Ctrl Supported	53%	Ctrl Supported	2%	3_Ctrl Supported
lp Vhembe District Municipality	Ctrl Supported	83%	Ctrl Supported	0%	3_Ctrl Supported
nc Frances Baard District Municipality	Ctrl Supported	67%	Ctrl Supported	0%	3_Ctrl Supported
nc John Taolo Gaetsewe District Municipality	Ctrl Supported	81%	Ctrl Supported	0%	3_Ctrl Supported
nc Namakwa District Municipality	Ctrl Supported	25%	Ctrl Supported	1%	3_Ctrl Supported
nc Pixley ka Seme District Municipality	Ctrl Supported	48%	Ctrl Supported	1%	3_Ctrl Supported
nc Zwelentlanga Fatman Mgcawu District Municipality	Ctrl Supported	40%	Ctrl Supported	2%	3_Ctrl Supported
nw Dr Ruth Segomotsi Mompati District Municipality	Ctrl Supported	53%	Ctrl Supported	0%	3_Ctrl Supported
wc Cape Winelands District Municipality	Ctrl Supported	399%	Ctrl Supported	0%	3_Ctrl Supported
wc Central Karoo District Municipality	Ctrl Supported	45%	Ctrl Supported	15%	3_Ctrl Supported
wc Eden District Municipality	Ctrl Supported	67%	Ctrl Supported	1%	3_Ctrl Supported
wc Overberg District Municipality	Ctrl Supported	74%	Ctrl Supported	3%	3_Ctrl Supported
wc West Coast District Municipality	Ctrl Supported	43%	Ctrl Supported	0%	3_Ctrl Supported
ec Nelson Mandela Bay Municipality	Sustained	34%	Sustained	0%	3_Ctrl Supported
fs Mangaung Metropolitan Municipality	Sustained	44%	Sustained	1%	3_Ctrl Supported
gp West Rand District Municipality	Sustained	58%	Sustained	0%	3_Ctrl Supported
kz Amajuba District Municipality	Sustained	55%	Sustained	1%	3_Ctrl Supported
kz iLembe District Municipality	Sustained	58%	Sustained	0%	3_Ctrl Supported
kz Umkhanyakude District Municipality	Sustained	67%	Sustained	0%	3_Ctrl Supported
kz Umzinyathi District Municipality	Sustained	56%	Sustained	0%	3_Ctrl Supported

lp Sekhukhune District Municipality	Sustained	47%	Sustained	1%	3_Ctrl Supported
lp Waterberg District Municipality	Sustained	61%	Sustained	3%	3_Ctrl Supported

Table A.2 ART Targets by Prioritization for Epidemic Control

Prioritization Area	Total PLHIV	Expected current on ART (APR FY 17)	Additional patients required for 80% ART coverage	Target current on ART (APR FY18) *TX_CURR*	Newly initiated (APR FY 18) *TX_NEW*	ART Coverage (APR 18)
Attained	2,004,148	1,596,454	6,864	1,711,026	269,709	0.85
Scale-Up Saturation	3,253,656	2,120,045	482,880	2,635,461	233,898	0.81
Central Support (KP and correctional facilities)	1,431,535	10,642	NA	10,642	957	NA
Commodities (if not included in previous categories)						
Total	**6,689,339**	**3,727,141**	**489,744**	**4,357,129**	**504,564**	

APPENDIX B

B.1 COP17 Planned Spending in 2017

Table B.1.1 Total Funding Level		
Applied Pipeline	**New Funding**	**Total COP17 Planned Spend**
$29,741,331	**$ 453,582,050**	**$$483,323,381**

*Data included in Table B.1.1 should match FACTS Info records, and can be checked by running the "Summary of Planned Funding by Agency" report.

***Table B.1.1 Resource Allocation by PEPFAR Budget Code** *Note: subject to final budget code allocations*		
PEPFAR Budget Code	**Budget Code Description**	**Amount Allocated**
MTCT	Mother to Child Transmission	$17,003,823
HVAB	Abstinence/Be Faithful Prevention	$5,414,914
HVOP	Other Sexual Prevention	$29,835,205
IDUP	Injecting and Non-Injecting Drug Use	$70,000
HMBL	Blood Safety	$0
HMIN	Injection Safety	$0
CIRC	Male Circumcision	$35,824,932
HVCT	Counseling and Testing	$35,691,717
HBHC	Adult Care and Support	$47,903,572
PDCS	Pediatric Care and Support	$8,090,431
HKID	Orphans and Vulnerable Children	$37,304,551
HTXS	Adult Treatment	$149,301,358
HTXD	ARV Drugs	$906,213
PDTX	Pediatric Treatment	$8,472,757
HVTB	TB/HIV Care	$34,493,642
HLAB	Lab	$4,330,889
HVSI	Strategic Information	$10,178,556
OHSS	Health Systems Strengthening	$25,906,624
HVMS	Management and Operations	$32,594,196
TOTAL		**$483,323,381**

***Table B.1.2 Resource Allocation by PEPFAR Budget Code (new funds only)**

Note: subject to final budget code allocations

PEPFAR Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	$15,651,084
HVAB	Abstinence/Be Faithful Prevention	$4,969,970
HVOP	Other Sexual Prevention	$28,039,162
IDUP	Injecting and Non-Injecting Drug Use	$70,000
HMBL	Blood Safety	0
HMIN	Injection Safety	0
CIRC	Male Circumcision	$25,615,740
HVCT	Counseling and Testing	$31,795,894
HBHC	Adult Care and Support	$46,718,062
PDCS	Pediatric Care and Support	$7,914,061
HKID	Orphans and Vulnerable Children	$37,213,069
HTXS	Adult Treatment	$146,421,984
HTXD	ARV Drugs	$906,213
PDTX	Pediatric Treatment	$8,346,387
HVTB	TB/HIV Care	$33,500,150
HLAB	Lab	$4,330,889
HVSI	Strategic Information	$8,833,076
OHSS	Health Systems Strengthening	$24,341,773
HVMS	Management and Operations	$28,914,535
TOTAL		**$ 453,582,050**

*Notes-Tables B1.1 and B1.2: The difference between Table B 1.1 and B 1.2 is the amount of pipeline applied by agencies in COP17; a total of $29,741,331 of previous years' funds is applied in COP17. The ~$453m includes $40m of treatment performance funding. In addition to the ~$453m, there is central VMMC funding of $51,503,884, of which $5m is performance funding. Decisions on performance funding allocation to the South Africa COP17 implementation will be determined after COP16/FY17 Q2 results review.

B.2 Resource Projections

Data was pulled from the Datapack for targets, PBAC and FSW reflect interagency planning and use of estimated unit expenditures, estimated service package costs, and budgets for above site activities.

APPENDIX C

Section 6.0 Tables: Program Support Necessary to Achieve Sustained Epidemic Control

Appendix C - Section 6, Tables summary will be posted separately and made available after submission 16 March 2017.